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ORIGINAL ARTICLES.

THE TREATMENT OF ALCOHOLISM.

[THIRD PAPER.]

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It is a common idea with the laity, and one which has not yet been wholly outgrown by the medical profession, that if a man has once been cured of the disease of inebriety, he will never drink again; and if, after having been treated for this disease, he should relapse into drinking habits, it is assumed that the treatment was ineffective, and the man was never really cured. Yet these same persons do not suppose that a man who has been cured of diphtheria by an injection of antitoxin can never thereafter contract the disease, or that a second attack of malarial fever proves that its subject was never cured of a previous attack. They understand that one attack of diphtheria does not protect against a second, except for a limited period; and that no matter how thoroughly a man may have been treated for malaria, if he continues to reside in a malarial district, and breathe an atmosphere laden with bacilli *malariae*, he will almost invariably suffer from repeated attacks of the disease.

In reality, the facts are similar in the case of alcoholic inebriety. One attack not only does not protect against a second, but it rather predisposes thereto. Medical treatment at the best cannot be hoped to

do more than place the man where he was before he began to drink. In fact, it cannot do even this; for the drunkard is a damaged man, mentally, morally, and physically, and no medicine can wholly do away with this fact, or remedy this condition. Though the cured inebriate no longer has any morbid craving for alcohol, yet he remembers what its effect has been upon him in the past, causing him to forget, for the time being, his cares, his sorrows, his poverty, and even his pains; and he knows it will do the same thing again if he gives it a chance. As he drank the first time from some other cause than appetite, so he can do again if he chooses. Alcohol made him a drunkard once, and it will do so every time the opportunity is offered. As a malarial atmosphere brings about a recurrence of malarial disease, so the saloon and drinking associates will surely lead to a relapse into drunkenness.

A recent writer in the *Journal of Inebriety*, Dr. C. Spencer Kinney, has well expressed the results of his experience in this matter as follows:

"A man who possesses a weak will, but little moral sense of responsibility, and a love of low associates, may be sobered up; but the length of time he will remain sober will depend upon time, place, and

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circumstances. The chances are that no treatment known will be of any permanent benefit to this class of patients.

"Some expect a complete change to occur in the character of the individual—a change making it impossible for him ever to drink liquor again. This is nonsense, born of ignorance of the subject. No treatment is going to benefit permanently any one who has no wish to stop drinking, and who prefers to associate with those who do drink. No one should be permitted to take treatment who does not honestly wish to be relieved of the drink thralldom. The taking of medicine will not render it impossible for a person ever to take liquor, nor will it restrain him from associating with those who habitually use liquor. It will remove the desire for liquor, rendering it unnecessary for the patient to drink again. It will also improve the patient's general physical condition, and enable him to entertain for himself some degree of self-respect. It will bring out the better qualities of the patient, that have been lying dormant under the influence of the drink habit. Should the patient attempt to recultivate the habit of drinking, there is no earthly reason why he should not (cannot) do it. Liquor will have the same effect upon him that it always had. Recollect that treatment will enable a man to remain sober if he so desires, and resolutely cultivates his regained self-control."

Should the question be asked, "How large a proportion of patients treated for alcoholism and cured of all desire for liquor will relapse, and what percentage will remain permanently sober?" I must reply, "I do not know." I am persuaded, however, that the proportion of permanently good results in these cases is as great as is common in any other disease of an equally serious nature, and far greater than can be secured by any plan which does not involve the removal of the appetite and the physical restoration of the man.

Dr. Keeley's claim of 95 per cent. of permanent cures is sheer nonsense, as any one can satisfy himself by a little observation of his results. Dr. J. M. Buckley, editor of the *Christian Advocate* (N. Y.), calculates, as the result of a large number of inquiries made by him, that nearly 50

per cent. of the Keeley "graduates" relapse within the first nine months after treatment. This proportion would doubtless be largely increased if the term included in the inquiry were lengthened.

Dr. Norman Kerr, of London, president of the English Society for the Study and Cure of Inebriates, reports that of the one hundred and fifteen cases discharged from the Dalrymple Home for Male Inebriates previous to January 31, 1888, fifty-two were doing well in 1891. This is a little more than 45 per cent. for a period of not less than three years.

Of eleven hundred patients treated at the Binghampton (N. Y.) Asylum, 61 per cent. were still temperate after a period of five years. Of two thousand cases treated at Fort Hamilton (N. Y.) 38 per cent. were still sober, after intervals ranging from seven to ten years. Statistics of the Washingtonian Home in Boston, comprising over three thousand cases, show that over 35 per cent. were healthy and temperate after intervals varying from eight to twelve years. In England and on the continent the different asylums report a percentage of permanent cures varying from thirty-two to forty-one.

My own experience has been too limited, both as to the number of patients treated and the time since they were treated, to be of much value. Of fifty cases, in which more than one year has elapsed, according to the best information obtainable, thirty-two remained sober at the end of that period, fourteen had relapsed, and four had passed out of my observation; so that I am unable to state the results in their cases. What proportion will persist for a period of five, ten or fifteen years remains to be seen.

It should be remembered that the proportion of relapses varies greatly according to the different classes of patients treated, as indicated by their occupation, education and social, financial and moral standing. Beginning at the bottom of the scale, with the criminal classes, the bums, tramps and dead-beats of society, it may safely be said that but few of them are worth treating. It is easy enough to sober them up and remove their morbid craving for alcohol. When this has been done, they are apt to be enthusiastic in praise of the cure,

and speak with unbounded confidence of their own future. But once they are turned loose upon the world and left to shift for themselves, they seldom fail to return promptly and regularly to the gutter from whence they were taken. Occasionally, even one of these disappoints expectations and goes back on all precedents by developing a good degree of manhood and self-respect and living a sober and clean life. But such cases are so rare as always to be a surprise. As a rule, effort is thrown away upon them. They are born degenerates, or else they have been so badly damaged by alcohol that the injury cannot be repaired. They are a class of men who are irresponsible in every walk of life. They have no mental balance, no moral stamina. And no form of medical treatment yet discovered can put backbone into a jelly-fish or brains into a fool.

The large body of honest laboring men, principally in agricultural, mechanical and clerical pursuits, furnish a much larger percentage of permanent cures. There is always hope for the men who will work; and, *per contra*, the man who refuses work when the opportunity is given him, is beyond hope. He may as well be left to die in the gutter, where his natural level is found.

The largest percentage of permanent cures will be found in the class of patients coming from the so-called higher walks of life, the educated and well-to-do, and those who are engaged in the professions, and in scientific and literary pursuits. These men are of a better organization naturally, and their surroundings are of a higher order, they have more to live for, more to induce them to stand. So, too, men with a home and family are far more likely to stand than the single men and homeless wanderers. Men who come from respectable families are far more hopeful cases than those whose origin is in the gutter. The stream cannot rise higher than its source.

Doubtless the real reason for the varying proportion of relapses found in these different classes, is to be found not chiefly in the occupation, education, pecuniary circumstances, or social standing of the patient, in themselves considered, but rather

in the factor which stands back of all these things; namely, those differences in the physical constitution, mental characteristics and moral stamina which have led to the differences in occupation, education and mode of life. The better a man's natural balance and force of will, the better are his chances of remaining sober and becoming a good citizen, when once the diseased appetite is removed.

As a result of these considerations, it will readily be seen that those institutions which receive their patients largely by legal commitments, and especially if they are made up of the habitues of the police court, may be expected to show a larger per cent. of relapses after treatment than those which receive only voluntary patients, and those mainly of the better class. The chief advantage in the former case lies in the fact that the patients may be detained for a longer time than they are usually willing to remain where the commitment is voluntary.

I cannot subscribe fully to the teachings of those who would, as I understand them, eliminate almost entirely the moral element from this great problem, and treat it entirely from a physical standpoint. I believe it is as much the duty of the physician who deals with inebriates, to do whatever lies in his power to rouse their manhood, strengthen their will power, and awaken in them a sense of moral responsibility, as it is to give them proper medical treatment; and, furthermore, that such efforts, in proportion as they are successful in accomplishing their direct objects, will have a tendency to increase the percentage of permanently good results, and lessen the number of relapses.

Of exciting causes, or occasions of relapses, there are many. Easily the first is licentiousness. More cured men are brought again under the bondage of drink, on account of, or at least in connection with, this vice—and especially by visiting houses of ill-fame,—than from any other single cause. The following case will serve as an illustration: A. B., laborer, married, with two children, was a "bum drunkard" of the irresponsible sort, well known on the street corners. He was treated for alcoholism in the winter of 1893-4, and remained sober for sixteen months. Dur-

ing this period he found good employment, gained his employer's confidence, and had the principal charge of a considerable business. At the end of the time stated, he suddenly became enamored of a woman of the town, and, leaving his family, home and business, followed her to a nearby city, where he lived with her—on his employer's money—according to all accounts, for three weeks before taking liquor of any kind, though the woman herself was frequently drunk. He then began drinking, and went on a protracted spree. In this case, it seems evident that appetite for liquor was not the first step in the man's downfall, but only came later, as the result of licentious indulgence and saloon surroundings.

The use of alcohol as a medicine is responsible for a certain number of relapses, though not so large a proportion, in my judgment, as is often charged to it. I always caution my patients on this point and advise them never, under any circumstances, to use alcohol as a medicine. Whatever their disease, they had better die sober than live and become drunkards. But I assure them that they need have no fears of dying from any such cause; for there is no condition of disease or accident likely to arise of all those which were formerly considered as calling for the use of alcoholic stimulants, in which the well-equipped physician of to-day does not possess safe and efficient substitutes, which will do their work even better than alcohol. Perhaps as a result of this teaching, in many instances, I have known my former patients to stoutly refuse whiskey and other alcoholics when ordered by a physician, and never in a single instance has any one of them suffered on account of this refusal.

In some cases, however, the result is less satisfactory. C. D., after being sober a year and a half, while traveling for a manufacturing company, was taken with a severe attack of the colic. He was stopping, at the time, at a country hotel, where liquor was sold contrary to law. He was urged to take some "cherry rum," and assured that it would cure him. He refused, giving as his reason that he had once been a drunkard and feared the result of taking a single glass. Still, the bar-

tender urged him to take one glass, assuring him that it would do him good, and there was no need of him making a fool of himself by getting drunk. This was an unusual case, for few men are vile enough to urge a man to drink under such circumstances. At last, after a night of suffering, he yielded, took the glass of cherry rum—and went out on a spree. However, this man did not really want to be a drunkard, and was not satisfied to continue in such a condition. Hence, after a few months spent in alternate sobriety and drunkenness, he returned to me for further treatment, and has since been sober.

Bad company and low associates cause the downfall of some. Poverty, lack of employment and domestic difficulties lead to the relapse of others. Opportunities are legion.

One fundamental point cannot be too strongly insisted upon. For all cured inebriates, *total abstinence is the only safe rule*. It may be that some men can drink moderately, and never become drunkards. But no one who has once been the victim of an overwhelming appetite, can ever afterwards be a moderate drinker. It is total abstinence or drunkenness for him. There is no middle way.

I cannot better sum up the case with reference to the results of treatment, than in the words of one of my own patients, who wrote me some time after leaving, substantially as follows :

"I find that in many cases a mistaken notion prevails in regard to the efficiency of cures for drunkenness. A man may fall into the ditch by accident the first time. But, when he is pulled out and put upon his feet again, and has the straight road pointed out and made plain to him, if he gets into that ditch again, he, only, is to blame. So it is with the treatment for alcoholism. The drunkard is thereby lifted out of the ditch, a very slough of despond, his appetite for alcoholic drinks taken from him to the extent of repugnance thereto; his manhood and self-respect re-asserted. Yet, withal, if he again consorts with his drinking associates, or falls back into his old haunts and habits, no one but himself can be blamed or held responsible for his willful backsliding."

IS THERE A DAILY RHYTHM IN EPILEPSY?

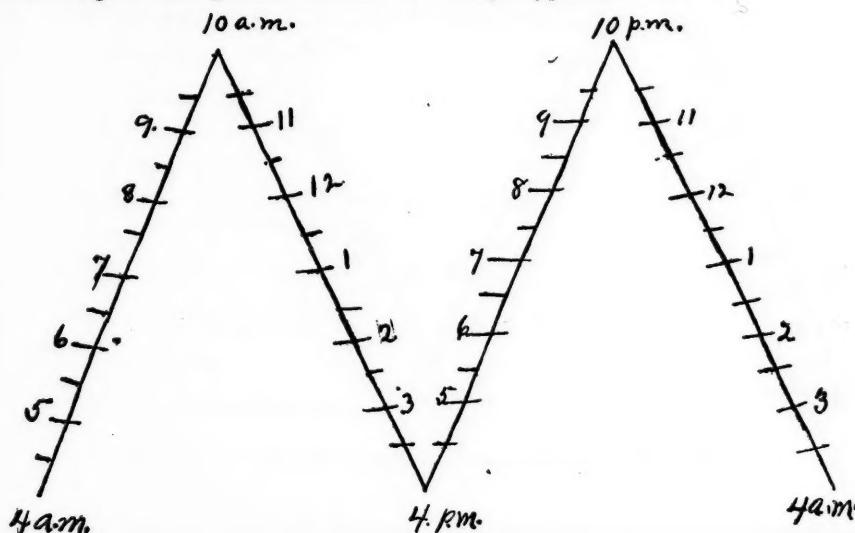
A. FERREE WITMER, M.D., PHILADELPHIA.

This paper is a preliminary report from the Pennsylvania Epileptic Hospital and Colony Farm, where the observations were made.

During a period of three months from January 1st, the convulsions occurring in twenty patients were noted, and exact time-records made for comparative study. Twelve of these patients were females, and eight males. Their ages varied from eight to fifty-three years.

Following the etiologic classification¹ of

after a careful examination for possible etiologic factors, particularly that of early cerebral or spinal hemorrhage,² we have called adolescent epilepsy. While brain-growth is practically complete at the close of the fifteenth year, yet as Venn³ found that the heads of the Cambridge students increased in length, breadth and depth throughout the collegiate course, it is probable that the disturbances incident to growth may be felt longer than is commonly supposed.



Physiologic Rhythm of the Nervous System. (The figures represent the hours.)

epilepsy as adopted by the Craig Colony, of New York, we find in our tables three cases of genito-neuropathic origin; two following infantile cerebral palsy (post-paralytic epilepsy), one of imbecilic type, and one acquired by vicious habits. There was no case of hystero-epilepsy; none due to trauma or to senile changes, and none inherited. There were, however, twelve cases in which the convulsive outbreaks began at periods varying from the ninth to the twenty-fourth year. These cases,

A time-interval of not less than fifteen minutes was permitted to intervene before recording the second of two seizures. This was done to avoid as far as possible the condition of status.

The number of convulsions tabulated is over twelve hundred. Consciousness was lost in each.

Bannister⁴ has recently contended that consciousness may be preserved during the seizure. It seems probable, however, that a careful analysis of such cases would re-

veal some disturbance of the conscious state. Wundt⁵ defines consciousness as the interconnection of psychic compounds, and further reminds us that every psychic compound requires the co-operation of numerous elements and many cortical regions. A disturbance of one of these cortical regions, such, for instance, as the arm-area, is sufficient to break the complex of inter-connection.

It is well known that the nervous system is subject to daily variation. This

which would vary in amount with the age of the animal, the nuclei regained their normal size.

Lombard⁶ ascertained by experiment that the energy in the muscles, and consequently also in the central cells, undergoes rhythmic variation in the course of each twenty-four hours. The result of these experiments I have attempted to show in the accompanying diagram modified from Lombard (Fig. 1). In the left-hand lower corner the marking 4 A.M.

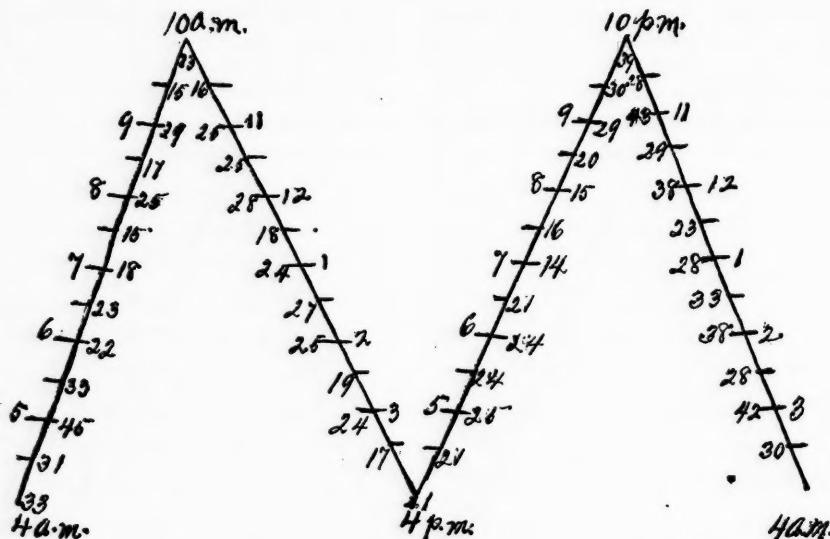


FIG. 2.

The lower figures represent convulsive seizures; the upper ones the hours.

rhythm is the outcome of a great biologic law, by which all sensitive vital substances are forced to alternate between rest and activity. In the nervous system, however, where this sensibility of the organism finds its most intense expression, the alternation of activity and recuperation is most marked.⁶

Fresh proofs of this are afforded by the now classic experiments of Hodge.⁷ This investigator stimulated by electricity the nerves leading to the spinal ganglion-cells of a cat, and at the end of one hour's time found that the nuclei of the stimulated cells had shrunk twenty-two per cent. After a period of sufficient rest,

represents the time of least intensity of the nervous system in the morning hours. From this time there is a gradual rise in intensity until the maximum is reached at 10 A.M. From then on there is a corresponding decline until 4 P.M., when the point of minimum intensity is reached in the early evening hours. This in turn is followed by a gradual rise to 10 P.M., and this again by a slow fall to 4 A.M., and so on. Frequent illustrations of these rhythmic states are afforded by bicyclists making a tour, who state that at eleven in the morning they would be riding swiftly with little effort; at about three in the afternoon they would begin to feel much

fatigued; while at six or seven in the evening their strength would seem to return like a tidal wave.⁹

The second chart shows the time-scale as in the preceding chart, with the addition of the total number of convulsive attacks for that time marked. (Fig. 2.)

In every case in which epileptic outbreaks occurred between the half-hours, credit was given to the half-hour the nearer in time. For instance, 12.12 is recorded as 12; 12.17 as 12.30, etc. When the

hibitory insufficiency in these states, as advocated by Langdon.¹⁰

Richardson¹¹ has recently reminded us that the most dangerous hours of the twenty-four to the melancholic are the latter hours of the night. Depression is then greatest, and the power of resistance to the suicidal impulse is least effective. This fact is of interest here, as we find that of the total of over twelve hundred seizures, seven hundred, or about sixty per cent., occurred during the dark hours, and

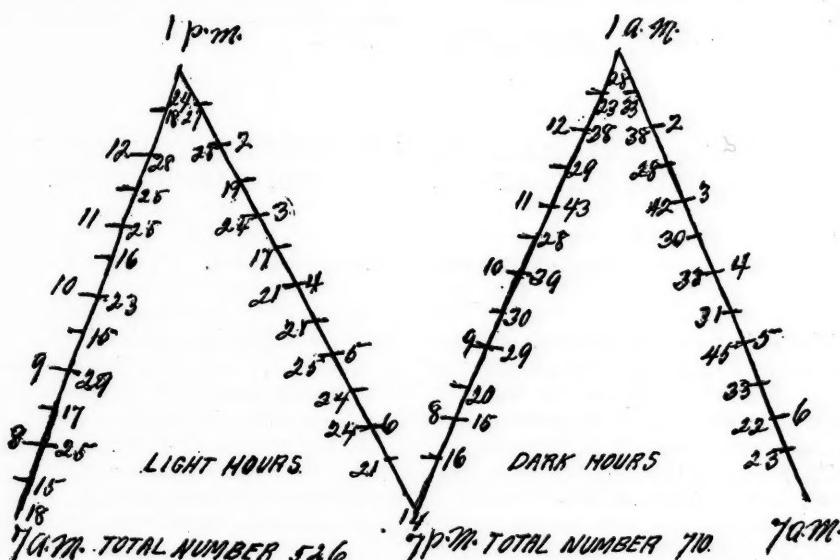


FIG. 3.

convulsions occurred at the quarter-hour, the number of convulsions for that time was equally divided between the hour and the half; thus ten convulsions at 12.15 are recorded as five at 12 and five at half after.

Glancing over the chart, it will be noticed that the greatest number of attacks occurred at 5 A.M.—forty-five, or one-twenty-seventh of the entire number being noted at this time. The least number, fourteen—one-eighteenth of the total—is recorded at 7 P.M.

This record is fairly in accord with the theory of a dynamic expression of an in-

this although but one of the patients had nocturnal epilepsy.

This proportion is shown in the third chart, in which the light hours, with the number of convulsions occurring at the different periods of time, are indicated in the left hand scale, while the corresponding dark hours are shown to the right of the figure.

The number of convulsive seizures that we have tabulated is doubtless too few to afford a basis for positive statements, yet the results obtained are strongly suggestive of an origin of the epileptic outbreak as advanced by Dercum.¹²

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REPORT OF A CASE OF LACERATION THROUGH THE SPHINCTER ANI, WITH REMARKS ON SUITS FOR MALPRACTICE.

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The accident of the burn in the case about to be reported presents some of those medico-legal phases in which, as general practitioners or surgeons, we are all interested. Reasoning from common-sense principles, that common sense upon which it is claimed all law is based, as medical men we are only responsible for those accidents preventable by reasonable or ordinary skill, care and diligence. We are certainly, by no principle of common justice, legally responsible, either criminally or civilly, for those accidents over which we have no control, or those the sequence of troubles, constitutional it may be, independent of those we surgically or medically correct or attempt to correct. Every self-respecting, conscientious physician expects to be held responsible for his results when they come within the limits of his control. This fact in itself puts him upon his best conduct, prompts the use of the best at the command of science, skill and the lessons of experience. The motives prompting these prosecutions, all the attendant incidents, have been and are more now than ever before, very closely analyzed by courts and juries, the animus, the mercenary motives at the bottom of

them are judicially considered. It is very rare, indeed, that a physician, reputable with the members of his profession and in the community, is guilty in any case of wilful maltreatment. He knows that such guilt, apart from criminal or civil liability, would close the doors of every honorable professional man against him, and close to him all avenues of legitimate and honorable practice. If fear of the law constituted no element of restraint in the matter, self-respect and self-interest would.

From the fact of the keen scrutiny of judges and juries into these cases not one in ten of the prosecutions for malpractice against regular and reputable physicians succeed. Yet there seems to be no avenue of escape from these vexatious, annoying, malignant and mercenary suits.

The suit instituted in the case of which I shall speak was evidently not thought of until after a bill for professional services had been rendered and payment demanded. The patient from the date of leaving the hospital seemed perfectly satisfied with what had been done for her, at no time complaining with any special reference to the accident or to her general treatment. I would here suggest as the best possible

safeguard against these suits that the surgeon receive his fee at the time of rendering his services. I have tried this rule and find it to work admirably. Having paid for services seems to have a very soothing effect upon the patient, whose general rest seems thus to be improved and who carries around with her less temptations for the lawyers.

The trouble growing out of the burn in the case about to be refuted resulted from several causes, presenting unique phases from a medico-legal standpoint. The woman had been in a helpless condition for twenty-eight years from loss of control of the bowel, broken-down health from confinement in the house owing to this cause. Her troubles were further aggravated by varicose ulceration and congestion of the limb, having had a number of open sores which it was very difficult to heal. The operation was a long one, and the surgical work was tedious. There were really two procedures: one for the removal of an epithelioma at the mouth of the bladder, and the control of the ensuing hemorrhage required considerable time. The closure of the tear in the sphincter required twenty-three stitches. The two procedures occupied more than an hour for their completion, so that the anesthesia was a long one. The patient was severely shocked when placed in bed. Her age, about sixty years, was also a factor to be considered. Hot applications protected by flannel at such a temperature as could be borne with comfort by the cheek of the nurse were made. Notwithstanding all precautions the patient was blistered on the inner side of the foot, and the burn was some three months in healing. Some one has recently written an article calling attention to the fact that a patient reacting from ether-anesthesia will suffer a burn or a blister from a much lower temperature than one who has not taken an anesthetic. I am not able to confirm this statement from my own experience, but I am constrained to believe that it is correct.

The second of my experiences was a suit by a man who had been suffering from influenza and who was unquestionably insane. To care for him I demanded that the family employ a competent nurse

or have him placed in a hospital to prevent his doing harm to himself, his family or his neighbors. They demanded a consultation, and Dr. F. X. Dercum saw the patient on the night of the same day I had informed the family of his condition. I was unable to meet the doctor, but he wrote me immediately, saying that if I did not have the patient removed at once he might kill somebody. I had given him a prescription for seven and one-half grains of chloral and an equal quantity of potassium bromid in a teaspoonful of sirup of red orange. In this suit for malpractice, the family fixed their claim for damages at five thousand dollars. This case remained on the docket for three years. It could not be forced to trial, and was at last dismissed, the plaintiff paying all costs and my bill in full for personal services, with interest from the date of its rendering.

The damage to the physician in these cases is not in a moral and professional way. In that direction rarely are they to any extent damaging; but they vex, take his time, the time to which his patients are entitled, break in on his business and necessitate the expenditure of some money in the preparation of his defence. These facts are well known to the class of patients who bring these suits and the class of lawyers who encourage them. The lawyer takes them on contingent fee—"Nothing if I can get nothing out of the doctor, and if I get anything about all I do get." He anticipates the terror of the doctor at being sued and that he will pay liberally to escape being taken into court. Every case compromised encourages such annoying and time-wasting legislation and is an injustice to the profession. Such a case should under no circumstances be compromised—not a penny for tribute, but all we have for self-defence.

Complete Laceration of the Perineum.—Dr. Hinkle asked me to see Mrs. Y. with him in consultation on October 1, 1894, with a view to an operation for the removal of a bleeding growth at the mouth of the urethra. It was a large as a hulled walnut, and gave her great pain and annoyance, with a constant discharge of blood and pus. This condition had been produced by the constant use of bandages and

cloths applied to the parts to prevent the intestinal discharges from soiling her clothing while sitting or walking. Examination disclosed the fact that the perineum had been torn through into the bowel for a distance of two inches. This occurred some thirty years before, when she was delivered of her only child. The growth presented all the appearance of malignancy, and to remove it and leave the cause would have been to insure its return. The woman was told that to prevent its return there would have to be an effort made to close the rent in the bowel so as to protect the mouth of the bladder. Dr. Thos. S. K. Morton had previously closed a vesico-vaginal fistula.

Up to this time the patient had refused any other operative interference, and would not now have consented had it not been for the condition of the growth. She stated that if both operations could be done at the same time, she would consent, as she was unwilling to take the ether twice. I agreed to take her into the hospital, and on December 10, 1894, she entered and was prepared for the operation, which was done two days later.

The patient was a large woman, and the parts were greatly swollen and irritated by the discharges from both the bowel and the malignant growth at the mouth of the bladder. The changes in the parts made the operation a difficult one. The tumor had to be removed first and then closure effected of the septum that separated the vagina from the bowel. This was done by cutting away all thickened mucous membrane over the parts that were united before the accident at child-birth, then closing from one inch above the top of the rent in the vagina and bowel, and continuing the stitches down to the outlet of the bowel, and finally exposing the ends of the sphincter muscle and re-uniting them after thirty years' separation and non-use. The closure required the use of twenty-three stitches. From non-use and atrophy of the muscle the mucous membrane protruded over the sphincter for about one inch and a half. To insure union this prolapsed portion should have been removed, but to do so would have been to prolong the operation to a dangerous degree, in the greatly debilitated

patient and one already greatly shocked from the ether and amount of work done. It is to be remembered that the woman had been a confirmed invalid during the entire period from the birth of her child to the time of the operation. When I first examined her, she told me that she could not go out without the liability of discharges from the bowel soiling her clothing before she would get off her front steps.

The operation was a greater success than we could reasonably have expected in a patient in such poor condition for so many years, and with the added complication of prolapse of the bowel. At the time she left the hospital she had a small fistulous opening near the bowel, from the giving way of one of the stitches. Her nervous system was so broken down that it was with the greatest difficulty that I could get her to let me remove the stitches and then only one or two at a time. She would shake the bed from fear even before anything was done.

After the operation, when the patient was placed in bed, she was greatly shocked. Warm blankets and hot bottles were applied, as in all other cases of danger from shock. From one of the bottles she received a blister on the right foot, under and a little to the front of the joint. This burn was so slight, that had the patient been in good condition, it would have healed in a very few days, but she had been suffering for years with varicose veins of both legs, with ulceration at times, that would not heal until the patient's condition was improved by treatment.

After the patient returned home I examined her, at the request of Dr. Hinkle, as he thought the malignant growth threatened to return. I found the fistula almost closed and leaking but little, and the sore foot healing nicely. The latter was completely well on March 1, 1895, as the patient informed Dr. Hinkle at that time. The fistula closed before the burn healed.

People who are susceptible to the cold should make a point of wearing loose clothing in cold weather. Loose garments are always warmer than tight-fitting ones, not only because they allow room for circulation, but also because they permit a layer of air between the skin and the outside cold.

CURRENT LITERATURE CONDENSED.

Iodoform Poisoning.¹

The expression "iodoform poisoning" is more familiar than definite. Most assuredly iodoform is very easily absorbed and very slowly eliminated—a most important fact in therapeutics. The raw interior of the uterus after delivery or abortion is particularly capable of absorbing the compound, but other wounded cavities, such as pouches left in connective tissue after the shelling out of tumors, also allow of active absorption if the dressing or powder be too firmly packed.

Twelve years ago large cavities in bones, after resection, were stuffed with the pure powder, hundreds of pounds of which were used in the wards of German hospitals. Dr. Brettauer, of New York, who is responsible for this statement, admits that it was not till many cases had died an obscure death that the possibility of iodoform being guilty of these bad results was even suspected. The special features in these fatal cases were cerebral symptoms, very rapid pulse without rise of temperature, and a peculiar odor of the breath, also noticeable in the wound.

Members of the New York Obstetrical Society observed these symptoms after packing cavities with iodoform gauze—a practice known as Mikulicz's drainage. The mildest symptom is cutaneous irritation, with an erythematous or eczematous rash, which seems always to smart and itch as in true urticaria. This condition is often seen in this country without any other symptoms. On the other hand, in extremely grave cases the patient is overcome by great lethargy, though there is at the same time insomnia, the pulse is very rapid, and death from syncope often follows. In an average case there is the cutaneous irritation, with marked headache and slight delirium, hallucinations, and above all an extremely rapid pulse.

While Brettauer declares that in the early cases of ten years since the temperature did not rise, New York doctors find that fever accompanies the high pulse. British observers, we believe, are in accord in this matter with their transatlantic brethren. All authorities are agreed that there is a remarkable rise in pulse. It may range from 120 to 150. After an abdominal section a high pulse is very alarming. Operators not only dread sepsis, but they fear that if they attribute high pulse and temperature to iodoform poisoning, others may accuse them of trying to explain away a truly septic condition.

Above all, it is the occurrence of the symptoms of iodoform poisoning after abortion and delivery that deserves rigorously close investigation. Is there a certain degree of sepsis in some cases in which there is really poisoning from iodoform? It is maintained that iodoform is a feeble and inefficient germicide, whilst nobody denies that it is to a certain extent poisonous. Is rise of temperature an essential symptom of iodoform poisoning? Mr. Stanley Boyd's case, reported by Mr. Watson Cheyne, has been quoted more than once, but "the temperature rose from normal to 104.6°," apparently not until the patient, aged 4, was moribund; again it is not absolutely clear that the symptoms were solely due to poisoning, and, lastly, the treatment was for a large spinal abscess.

In such a case it is not so easy to differentiate causes of bad symptoms as in a woman who has just aborted or been delivered. In parturition, moreover, a greater direct responsibility lies with the medical attendant, so that if he has packed the uterus with iodoform gauze, it is very important that he and all others whom the case may afterwards concern should feel sure as to the signification of untoward symptoms.

¹British Medical Journal.

Successful Cesarean Section After Death.²

There can be no doubt that the aim of the obstetrician is to save both mother and child. When there is any difficulty about the rescue of both, the mother must first be considered. When the mother is already dead, the child is usually dead also, but this is not invariably the case. The medical attendant should certainly save the child if he can, but for obvious reasons he may be prevented, especially in private practice. The patient's relatives may well feel more respect for a corpse than solicitude for an unborn infant. Yet it is well to remember and to remind them that the child may be saved.

In the obituary notice of Dr. Harley mention was made of his success in saving a child after the mother's death. The patient was suffering from mitral obstruction and aortic regurgitation; there was anasarca, but it would appear the urine had only been tested once, ten days before death, and no albumin was detected. The kidneys were found "full size and quite healthy." On April 25, 1850, the woman, in the beginning of the ninth month, had a fit of dyspnea in the kitchen of the Edinburgh Royal Maternity Hospital. Harley, then house-surgeon, diagnosed spasm of the glottis, and performed laryngotomy.

The dyspnea increased, and he was beginning the operation of tracheotomy when the patient died. He immediately tore through the patient's dress, opened the abdominal wall and the uterus, seized the child by the leg and delivered it. It was in a state of suspended animation; cold water, inflation, and artificial respiration revived it, and the cord was cut. The child was a male, weighing 6 lbs. 12 ozs., and measuring 18½ inches. Not more than twenty minutes elapsed from the time the patient was seized in the kitchen till all was over, including the stitching up of the abdominal wound and the removal of the mother's body. The child not being premature was easily reared, and grew up to manhood.

A very interesting case of successful post-mortem Cesarean section has recently been reported by Sandberg, of Christiania. He operated under very unfavorable con-

ditions, as the mother had died of eclampsia, an affection very perilous to the fetus. The patient was a primipara, aged 36, and expected her confinement on September 20, 1895. In July of the same year anasarca set in. On August 18 she died comatose, after numerous attacks of eclampsia. Four minutes after the heart-sounds had ceased, Cæsarean section was performed.

The uterus was opened after the escape of much ascitic fluid. The child was born asphyxiated, but breathed well a quarter of an hour after delivery. It was under 4 lbs. in weight, and not 16 inches long. Placed in an improvised *couveuse*, it was fed with a mixture of 1 part milk, 3 parts water, and 4 per cent. sugar of milk.

The infant was successfully reared, and was living in October, 1896, when the report was published. This remarkable case of the delivery and rearing of a truly posthumous child is a triumph for the *couveuse* as well as for the well-timed operation, for which Dr. Sandberg deserves credit.

We have already noted its ethical bearing, an interesting question for medical jurisprudence. As Spiegelberg has pointed out, Roman law directed that before the corpse of a pregnant woman was buried, Cesarean section should be performed. By Prussian law, the performance of Cesarean section on a woman who has died during pregnancy, is left to the judgment of the medical attendant in the particular case. Lœwenhardt and others advocate the operation when the mother is in *articulo mortis*, but though this doctrine is based on a high principle, it is contrary to higher sentiments, and does not find favor either with the profession or the public.

Formaldehyd.³

A new antiseptic, formaldehyd, has recently made its appearance and bids fair to divide the field of usefulness with corrosive sublimate, as a general antiseptic agent. In its purity it is gaseous at ordinary temperatures; it is colorless, but has a pungent, penetrating odor. Its chemical formula is CH₂O. There are several methods according to which it may be

² British Medical Journal.

³ Editorial in The Pittsburg Medical Review.

made by the limited oxidation of methyl alcohol. The product of this process is a solution of the formaldehyd in methyl alcohol. The highest degree of strength in which it is possible to produce it is forty per cent.; a strength above this tends to change into a solid form, paraformaldehyd, which possesses but little activity. Exposed to the air the solutions lose strength by evaporation, and it is this tendency to volatilize which makes it specially valuable in the disinfection of rooms, or, in fact, of anything which may not be placed into water. In addition to its antiseptic powers it is of great value in microscopy, as a hardening agent.

It is recommended in dilute solution as a means for the disinfection and to preserve the pliability of the piston leather of syringes.

Its action, when taken internally, does not seem to be well established, though it does not appear to possess any decided degree of toxicity on the human organism. Dairymen, it is said, are using formaldehyd as a preservative of milk, and in view of its apparent harmlessness it would seem that a field of usefulness may be open here, if it should be found to destroy the various pathogenic germs often found in milk without affecting it deleteriously. The different uses to which it has so far been put and the strength in which it seems best adapted to exert its antiseptic and hardening powers, are well given in the table below, taken from an article by F. J. C. Bird in the *Pharmaceutical Journal*. The one part of formaldehyd in this table represents two and one-half parts of the full strength, or forty per cent. solution of commerce:

1:125,000 kills anthrax bacilli.

1:50,000 prevents the development of typhus bacilli, etc.

1:32,000 preserves milk for several days.

1:25,000 forms a useful injection in leucorrhea, etc.

1:20,000 preserves wines, weak alcoholic liquids, and beer, also milk for several weeks.

1:4000 is recommended for moistening paper used to cover jam, etc.

1:3200 for rinsing dairy vessels, etc.

1:2500 destroys the most resistant microorganism in one hour.

1:2000 for rinsing casks and vessels intended for liquids liable to fermentation.

1:500 for the irrigation of catheters, etc., and as a mouth-wash.

1:250 to 200 is a general disinfectant solution for washing hands, instruments, etc., in surgery, spraying in sick-rooms, and as a deodorant.

1:160 to 100 hardens microscopic tissues, which should be immersed for a considerable time to give the best results.

1:100 in lupus, psoriasis and skin diseases.

1:50 to 25 sterilizes surgical catgut, silk, etc., by steeping.

1:25 for quickly hardening and preserving for microscopical sections; longer immersion in a weaker solution gives better results.

1:10 for hardening very firm tissues in pathological and histological work.

1:5 for hardening firm tissues in such work.

1:2 $\frac{1}{2}$ for hardening soft tissues for the same purpose.

The fact that water absorbs it readily to the extent of a forty per cent. solution renders it easy of application as a disinfectant, and it is in this aqueous solution that it is found in the market, and is thus miscible with water to form any degree of strength desirable.

The Prevention of Venereal Disease.⁴

In the whole range of preventive medicine there is no single class of disease that has hitherto appeared more hopeless as to its outlook than that which is commonly described as "venereal." The difficulties with which the subject has been surrounded have issued, for the most part, from a sentimental source. In defiance of the dictates of modern prevention, a specific and peculiarly preventable disease has been allowed to run riot, simply because certain sentimentalists have chosen to place the dogmas of their morality above the wholesome maxims of modern social science. The ancient attitude of these abstract philosophers is to turn aside like the Pharisee of the parable, and then to imagine they have done their duty by the poor wretch stricken down with a

loathsome disease at the side of the highway.

Nowadays, a logical and pitiless analysis of all the complex conditions of human life is to be witnessed everywhere in the striking departures of advanced thought. Plain speaking is the rule on all matters directly or indirectly involving sex problems, and the tendency may ultimately make for the elevation of mankind. At any rate, it may be fairly asserted that many centuries of abstract optimism have failed to abate by one jot or tittle the scourges of syphilis and gonorrhea. The question that has been so disastrously shelved by the moralists must now be approached by other and more reasonable methods.

Prostitution is an admitted evil, but it is none the less the outcome of one of the strongest natural instincts common to all animated life. It is a practice surrounded with peculiar dangers to the health of the community, but which can be curtailed by a supervision like that enforced in the cases of other infectious maladies. Let prostitution, then, be brought within the bounds of administrative official control, and at the same time let all who are suffering from venereal diseases be placed under the purview of the Notification Acts.

So far as the military service of the British Empire in India is concerned the matter may, perhaps, advantageously be put in the following way.

It is clear that the moralists who preach at home avail themselves of the principle of the division of the labors of the community by hiring a body of men to protect them and fight their battles. The soldiers thus engaged are naturally chosen from young and able-bodied males, who are well fed and housed, and to whom marriage is forbidden. What wonder, then, if healthy and high-spirited young men in such an environment should recklessly incur the risks attached to illicit sexual intercourse? In India, especially, the stimulus of a hot climate is an additional incentive to indulgence. These are the plain facts of the case, and as such they will have to be faced.

That the present system cannot be allowed to endure is evident from the ter-

rible disclosures of the report of the departmental committee appointed to inquire into the subject. One of the most hopeful signs of the break-up of the reign of the sentimentalists is the way in which this matter is being almost universally discussed in the public press. An open treatment of such a question would have been impossible ten years since. But the restless spirit of the age speeds onward unceasingly from one intellectual revolution to another.

Guaiacol in Puerperal Eclampsia.⁵

When guaiacol is poured upon the abdomen it is rapidly absorbed. Its physiologic effect is to cause rapid and marked lessening of arterial blood-pressure, lowering of temperature and free diaphoresis. These physiologic effects first led me to use it in a case of nephritis attended with slight convulsions and a full, hard pulse. This patient was an adult male. Twenty-five drops were poured upon the abdomen, and rubbed in with the tips of the fingers. Relief was certainly marked.

Next I used guaiacol in two cases of puerperal eclampsia, with surprising and happy results. They were primiparae. In the first, labor was progressing favorably, dilatation had been accomplished, and the occupant had begun to descend, when convulsions came on, becoming more profound with each recurring seizure. As soon as practicable, chloroform was administered, and the child, a large male, was delivered with the forceps. On the effect of the anesthetic wearing off, the convulsions returned; whereupon I poured forty or fifty drops of guaiacol (the case seemed too urgent to take time to count the drops) upon the abdomen, and gently rubbed them in as in the preceding case. In a few minutes the pulse became soft, free diaphoresis set in, and the convulsions died away.

The second patient had been delivered by a midwife. Both baby and placenta had come away when convulsions set in. On arriving at the bedside, I found that the patient was enormously swollen over the whole body, and the pulse was full, hard and tumultuous. The convulsions were almost continuous. They were as

⁵J. F. R. Appleby, A.M., M.D., Washington, D.C., in *Boston Medical and Surgical Journal*.

powerful as, if not more powerful than, any I have seen in a practice extending over nearly thirty years. It looked like a hopeless case. As with the other patients, I used forty or fifty drops of guaiacol and gave a hypodermic injection of one-fourth of a grain of sulphate of morphia. In less than an hour the patient was sleeping quietly, and no more convulsions followed.

Both of the above cases had albuminuria and were much swollen, which symptoms demanded treatment for a few days. Both made good recoveries, and are now enjoying ordinary health.

For guiacol there may be claimed certainty of action, speedy relief of urgent symptoms and ease of application, which renders it, perhaps, more desirable and less objectionable than any of the remedies heretofore used in eclampsia. In neither case did I find it necessary to make a second application, but would certainly have done so had it been necessary.

The Irrigation Treatment of Gonorrhea.⁶

Recently published formularies seem to have created the impression that all gonorrhoeas are curable in eight days. As in all methods of treating any disease, circumstances, personal experience, the dexterity acquired by practice, influence the course of the ailment. Without reference to the mixed infections, consequently those in which the disease-provoker is the gonococcus alone, with irrigations without a catheter use mainly potassic permanganate. Goldberg shows that of acute gonorrhoeas, sixty per cent. are so cured within 10 days, thirty per cent. in 14 days, five per cent. required longer time because of violations of the injunctions regarding coitus and alcohol, and five per cent. were unexplained failures. American experience differs in that the failures are within two per cent.

I have had 82 cases of genuine gonorrhœa which recovered within three days, but all were patients who began irrigations when the meatus presented only a slight mucoid excess of moisture. On microscopic examination this was found to contain gonococci.

The irrigator placed at 9 feet from the floor gives adequate hydrostatic pressure to overcome the most resistent compressor. Lesser force, required for irrigating the anterior urethra, is easily obtained by the operator's thumb, with the present stop-cock. Perhaps less than one per cent. of patients complain of pain during irrigation. The exceedingly few who do, can be relieved by precursory injections of cocaine. The pain, however severe, usually ceases after the first irrigation. No drugs are used internally, except to meet other indications, as constipation, then giving cascara sagrada.

There is no reason for patients to abstain from any kind of food during this disease. The habitual amounts of coffee, tea or chocolate are permitted, but all carbonated drinks (vichy, seltzer, ginger-ale, root-beer, sarsaparilla, etc.), are strictly forbidden, as are all wines, liquors, beer, except to those who are accustomed to drink claret at meals. It is not evident that tobacco in any manner influences gonorrhœa, therefore abstinence therefrom is not ordered. Refraining from moderate exercise cannot contribute to the patient's general health, therefore it should not be forbidden. The shower bath is preferable while gonorrhœa lasts.

In the hands of those who irrigate carefully, no complications ever result. Catheter fever, a very frequent sequela to urethral instrumentation, is entirely avoided by irrigating the urethra or bladder without a catheter, according to the region invaded usually with potassic permanganate 1 to 6,000.

It is difficult to imagine a chronic gonorrhœa without changes in the tissues of the urethra. Should such a one present with too copious a discharge or too sensitive a urethra for instrumental examination, the series of irrigations proposed by Janet would check it. Experience has shown that the urethroscope will always reveal at least one lesion, without whose treatment the case will not yield to irrigations alone.

The only proper method of protecting the garments is by dressing the glans with absorbent cotton soaked in mercuric bichlorid, 1 to 6,000. If the prepuce is not large enough to hold the cotton, it may be

⁶ Ferd. C. Valentine, M. D., in the *Clinical Recorder*.

made fast to the penis by a light bandage of gauze. The cotton and bandage worn should be burned after each irrigation and urination.

The importance of deciding whether a gonorrhea is definitely cured, is beyond discussion. It will suffice here to cite the tests employed: 1. A week after every vestige of discharge has disappeared and the urine has remained perfectly clear, the patient is ordered, before retiring, to drink double the quantity of beer he used previous to his infection.* If the next morning or the following one, reveals no return of the discharge, the patient is dismissed for a week. 2. Then an irritant injection of silver-nitrate is made into the urethra. A discharge is produced thereby in from 4 to 16 hours. This discharge is examined for gonococci. If none be found, the discharge is allowed to recover without treatment. 3. Then the patient is instructed to use a condom in case he indulge in sexual intercourse and to bring the condom for examination. If its contents are found to be free from gonococci, then 4, a urethroscopic examination is made. If this shows a perfectly healthy urethra, the patient certainly may be deemed cured.

It often happens that the entire penis becomes exceedingly edematous after an irrigation. If the patient is not forewarned of this possibility, he may grow alarmed enough to desist from treatment, although the swelling is entirely painless and harmless. Indeed, in my opinion, it is this artificial edema which, though it be unperceived by the patient, renders the urethral mucosa an inferior culture-medium for gonococci; their nutrient thus being vitiated or entirely destroyed, their proliferation is checked.

The first irrigation is usually followed by an arrest of pain and a reduction of the heavy thick discharge to a slight, often colorless, excess of moisture. The patient must be warned that this trifling excess still can contain gonococci. Therefore, after touching the penis, the hands must be scrupulously washed, lest they carry infection to the patient's eyes, which may be rendered irretrievably blind in 48

hours, from the resultant gonorrhreal ophthalmia.

Indications for the Use of the Obstetrical Forceps.⁷

Professor T. G. Thomas, of New York, in his lecture on obstetrics, summed up the indications for the use of the forceps as follows: 1, to supply force; 2, to overcome obstruction; 3, to hasten delivery; 4, to alter the position of the head.

These indications cover the whole field for the use of the forceps. The first indication is called for nine times out of ten in powerless labor, the pelvis and passages normal, and the fetus normal, additional force being simply required to accomplish the delivery.

In the second indication there is obstruction in the pelvis, or the passages, or in the fetus, although the pains may be normal and energetic enough to deliver the fetus if there was no obstruction.

The third indication is called for chiefly in convulsions and hemorrhages.

The fourth is a faulty position of head of the fetus; and also where there is a contracted antero-posterior diameter where the head does not enter the pelvis on account of it, but where there is plenty of room in the oblique diameter and a sufficiently roomy outlet.

To use the forceps with the greatest safety to mother and child, imitate nature. Anesthetize the patient, apply forceps, and then remove the chloroform until a "pain" comes on; then give chloroform again and make traction with the pain for from one to two minutes, and then let up entirely so as to take all pressure off the child's head, and then wait until the next "pain" comes on, which you can always tell, even if the woman is sleeping, by seeing the handle of the forceps move. Always give the chloroform during the traction, and only at that time. By making traction during a "pain" and giving chloroform at the same time, and then a period of rest, you give time for the parts to dilate, and are not apt to have any rupture. When the head has been brought down low enough to reach the forehead, with two fingers in the rectum, we remove the

* The beer-test is omitted in abstainers from intoxicants.

⁷ Charlotte Medical Journal.

forceps and, with the two fingers in the rectum, lift the head toward the symphysis pubis until the perineum is put on the stretch, seeming as if it could not stretch any more without a tear. Then let up for a few moments, and then continue in the same way until it is delivered.

When the head of the child is at the inferior strait of the pelvis, we do not move the woman from the position she is occupying in the bed, because the traction is made in the axis of the outlet of the pelvis and there is no necessity for moving her. Of course, if you apply the forceps at the superior strait of the pelvis, then you will have to put her across the bed and bring her hips well to the edge of the bed, in order to make your traction in the axis of the superior strait. Apply the left-hand blade first. Sometimes there is some difficulty in locking the blades. When that is the case, push the handle of the blade first introduced back toward the coccyx or sacrum, and you will find it go higher up into the uterus. Do the same thing with the other blade, and you will find they then lock with ease. The most harm done with the forceps is due to continuous traction after their application, and, next to that, traction in the wrong direction.

The Internal Secretion of the Ovaries.⁸

At a time when ovariectomy is so common an operation, it may be of interest to give some extracts from an important article published recently in an Italian journal (*Annali di Ostetricia e Ginecologia*) by Drs. Guratulo and Tarulli, of the University of Rome. This article is of special interest to obstetricians on account of the influence attributed by the authors to the ovaries in the production of osteomalacia, and the suggestion of the employment of ovariectomy as a means of treatment of this disease. The authors first determined the influence of removal of the ovaries upon the composition of the urine, and upon the respiratory exchanges. The animals on whom the experiments were made were kept upon a constant diet for a considerable time before operation, in

order to arrive at the proper average excretions of nitrogen phosphates and products of respiration. The diet was unchanged after operation. Great care was taken to remove the glands entirely, and not to overlook the possible existence of supernumerary ovaries. The results of these observations were as follows:

1. The ablation of the ovaries has a notable influence upon the organic exchanges.
2. The elimination of phosphates in the urine is greatly decreased after the operation. This decrease is due neither to diet, which was unchanged, nor to any diminution in the absorption from the intestine, as was shown by the absence of gastro-intestinal symptoms, and also by the persistent increase in weight, and the analysis of the feces.
3. The elimination of nitrogen was unchanged after operation.
4. The amount of carbonic acid excreted, and of oxygen absorbed, was markedly decreased.
5. The weight of the animals steadily and invariably increased after operation.
6. The injection of a certain quantity of ovarian juice into the subcutaneous cellular tissue of animals after operation, and the resultant diminution of the excretion of phosphates, causes this excretion to increase, and even to exceed the amount eliminated before operation. This augmentation is not in proportion to the amount of phosphatic salts contained in the ovarian juice injected.
7. The removal of the uterus at the same time with the ovaries does not apparently modify in any way the results observed when the ovaries alone were taken out.

In an examination of these results, and the tables accompanying them in the original article, there are several things that attract our attention. We notice the diminution in the respiratory exchanges, a diminution that under the conditions of the experiments cannot be attributed to diet. The constant increase in weight is noteworthy, and is attributed by the authors to the lessened oxidation of the fats in the diet.

⁸ W. L. Adams, M.D., in *Pacific Medical Journal*.

But the most interesting result obtained is the discovery of the diminution of excretion of phosphates, and the increase of that excretion in animals that had been operated upon under the influence of the injection of an ovarian juice. This phenomenon has led the authors to admit the secretion in the ovaries of an unknown substance capable of favorizing the oxidation of the organic compounds containing phosphorus, and also has suggested to them an explanation of the favorable therapeutic results obtained by removal of the ovaries in osteomalacia.

The authors do not believe that this disease is due to the ovary alone, in fact they are of the opinion that it is a germ disease in spite of the negative result of bacteriological examination up to the present time. But they hold that the removal of the ovaries, by producing favorable modifications of the organic exchanges, brings about the condition essential to the cure of the disease by checking the waste of phosphates. Were it due to the ovary alone, this disease ought to be capable of being produced by injecting large quantities of the juice of that gland into the organism of animals that have not been castrated; but this experiment was unsuccessful in the authors' hands.

In support of their theory of the internal secretion of the ovaries, they also call attention to the modifications produced in the female organisms by puberty menstruation and the menopause, modifications that are always marked by great variations in the exchanges and oxidations.

The general conclusions of the article were: That the ovaries have, like the other glands of the body, according to the doctrine of Brown-Séquard, a form of internal secretion. They continually pour into the blood a product of their secretion, whose chemical constitution is at present unknown, and whose most essential characteristics are to favor the oxidation of hydrocarbons, fats, and substances containing phosphorus.

Their removal, or the absence of their function (as before puberty or after menopause) will cause on the one hand a greater retention of the organic phosphorus, whence the accumulation of lime-salts in the bones; on the other hand the

well-known phenomenon of fattening consecutive to ovariectomy and then menopause.

Eunuchs in China.

The emperor and certain members of the royal family alone are allowed to keep eunuchs. His majesty maintains three thousand, while others are permitted to keep only thirty. Greed, predilection, poverty, and laziness are the four factors in the production of these eunuchs. Dr. Matignon describes the operation somewhat as follows: The subject, with his abdomen and thighs tightly bandaged, is placed upon a low bed, and his legs are widely separated. The operator uses a knife resembling a pruning-knife, or occasionally a pair of scissors. With his left hand he seizes the parts, twisting and squeezing them to diminish the supply of blood; a single rapid sweep of the hand serves to remove the penis and scrotum, the blade of the instrument passing as close as possible to the pubis. No anesthetic is used. A small piece of wood or pewter, the shape of a nail, is then inserted in the urethra; the wound is washed two or three times with pepper and water, and, several pieces of paper having been applied to the surface, the parts are carefully and tightly bandaged. Immediately after the bandaging the patient is forced to walk up and down the room rapidly for three hours. For three days he is not allowed to eat anything, and he not only endures the pangs of thirst, but he also suffers the agonies of retention, owing to the plug in the urethra. On the fourth day the bandage is removed, and the wretched creature is permitted to pass urine if he can. If the urine flows he is looked upon as cured, but if the overstrained bladder refuses to act he is allowed to die, as the Chinese know nothing of catheterization. Notwithstanding this primitive mode of treatment the operation is usually successful—the fatal cases do not amount to more than three or four per cent. The most frequent complication is said to be incontinence of urine, but if this persists after a reasonable period the patient is condemned to flagellation, which is reported to yield most excellent results.—*The Lancet.*

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EDITORIAL.

START RIGHT.

In a few days several thousand graduates in medicine will face the world, with the necessity, more or less urgent, of wresting their living from it. For some, this necessity is only to insure self-respect, by demonstrating the ability to gain a livelihood; for the majority, it is a much sterner reality; for not a few, it is a matter almost of days when their present means will have become exhausted. Their is one fact which is most unpleasant to express, but which the new-comer will soon ascertain, and of which he must make the best. Excepting those men, whose medical course has been taken with the purpose of assisting a father, uncle or other interested practitioner, the thousands of recruits will find absolutely no need of

their services in any place which has more than a few thousand inhabitants.

There are many small villages and "corners," whose inhabitants are suffering for lack of competent medical attendance. The physician may have died, recently, or become decrepit, or he may be the victim of alcohol, morphin or cocaine, or he may be notoriously incompetent. In such places the young physician will find a warm welcome. But he must be sure that the conditions mentioned are fulfilled, and that a vacancy does exist. He must not argue that, because the single doctor of a small community is many years removed from college days, he is behind the times, or ready to relinquish his practice to a stranger. Some of the best material in

the profession is distributed among communities, each of which can adequately support but one physician, and such a community as these would be the very worst place which the recent graduate could select.

If the town chosen is one which has a population of even a few thousand, there will be in it twice so many physicians as are necessary, some good, some bad, some successful, some unsuccessful, and with only an approximate relation between merit and success. The man who chooses a small town and visits his established rivals, will learn from them, if candor gets the better of courtesy, that he is a superfluity, that every dollar which he may earn will be an appreciable—though ungrudged—subtraction from the income of those already in the field. If he selects a large city, he will be even more apt to meet the sentiment—and usually expressed in so friendly and impersonal a way that he can take no offense at it—that matters are so bad already, and physicians so numerous, that a few more or less will make no difference.

This awkward position, in which the recent graduate is placed, tends to influence him in one of three directions. First, either in disgust, or as a matter of philanthropy, he may drop out of the contest at the very beginning; secondly, he may decide to advertise his trade, and make his professional equipment a mere business outfit; thirdly, he may make up his mind that his excuse for existence as a physician depends upon his ability to demonstrate, by patience and sagacity, that he can fill a place which no other man already fills, and for which no other is exactly adapted.

There seems no valid objection to the abandonment of practice, except that the man who does so must necessarily look back upon his medical course as a waste of time and money, and as an unrequited

hardship. Still, there are a number of well-to-do business men, who have taken this course, who scarcely regret their medical studies, and who certainly recognize that they are better off than their classmates, who persevered in the practice of medicine. And, on the other hand, it must be admitted that a number of eminently successful medical men can be named who were narrowly deterred from such a course, or who returned to practice after some experience with business.

The attainment of a reputation, even the local reputation of being a physician of honest purpose and fair ability, is tedious, and the reward for the labor is tardy and inadequate, yet this rugged path is the only one which leads to genuine success, and only those who have traveled it can enjoy to the full the exhilaration of triumph. The man who has been set on an eminence by favorable influences, or persistently boosted by a patron, may be as honorable as the man who has climbed, and he may reach a greater height, but he can never feel quite so independent as the latter, nor win quite so full a measure of appreciation from his associates.

The death of a man who chose the second method of extricating himself from the trilemma, which confronted him at the close of his medical course, was recently reported. His life history is about as follows: A man of considerable natural ability, he secured a liberal education, supported himself and family in comfort for a few years, then decided to study medicine, which he did at great sacrifice, in which those depending on him shared. His resources, financial and physical, were strained to the utmost to reach Commencement day. Unable to support himself till his practice might become remunerative, unwilling to return to the honorable and fairly profitable occupation of former years, he obtained employment in a large

advertising institution. Here he found himself provided with the necessities and some of the comforts of life, but his chances of promotion were almost *nil*. A few attempts to renew the acquaintances of his student days, and to participate in professional activity, proved most embarrassing. It was impressed upon him that he had "soiled the nest in which he had been reared," and it must have been with the conviction of a life misdirected that he left this world.

Such men are largely the victims of circumstances, but it ought to be evident to every intelligent individual that it is foolish to seek admission to any place in the social structure, unless one is able to occupy that place honorably, and in accordance with established and rational customs. It is difficult to appreciate the ambition of a man to gain admission to an honorable profession, unless his ambition is also to practice that profession in an honorable manner.

ABSTRACTS.

SOME THINGS I WAS NOT TAUGHT IN OBSTETRICS.*

Was it Horace Greeley who said of a certain self-styled "self-made man" that he relieved his Creator of a very grave responsibility? My instructors cannot be held accountable for my conclusions. Possibly a better title would be "Some Things I Did Not Learn in Obstetrics." However this may be, the fact remains that I did not know them upon leaving the medical school, and they had to be developed from experience, or the application of general principles, though often from current literature and oftener still from the suggestions or hints of others.

It is hard after twenty years of active practice to recall just what definite ideas on obstetrics were fixed in the mind on leaving the medical school. The professor praised ergot, and had talked about and shown the forceps, but advised against taking the latter with us to a case lest we should be tempted (?) to use them.

At the same time, the gynecologists were doing their best to teach us how to cure vesico-vaginal fistula. It was not

till years after that the interdependence of these two lines of teaching dawned upon us, and our respect for the professor of obstetrics began to wane.

Those were the days when one justified a masterly inactivity by expressed distrust for all so-called "meddlesome midwifery." Antiseptic surgery was preparing the way for later aseptic triumphs, but the application of its principles to obstetrics was not being generally or enthusiastically tried.

About this time, some English medical journals described and figured an obstetric bag with its suggested contents, and one can remember how pedantic and fussy such an article seemed. But as years went on the bag became a fixture, and with its general adoption the practitioner found ready at hand anesthetics, well-adapted instruments, antiseptic materials, needed drugs and dressings. Thus the doctor's time was saved, and what is far more to be rejoiced in, woman was relieved of much of her great primal pain and danger, so that for some years past, less has been heard of "meddlesome midwifery," and fewer women suffer from vesico-vaginal

* E. S. BOLAND, M.D., in the *Boston Medical and Surgical Journal*.

fistula, while fewer die from puerperal fever. The obstetric bag then, with the training to use its well-selected appliances, represents the evolution of anesthetic, aseptic midwifery of to-day.

The use of anesthetics habitually in labor was not taught us, even when desired by the patient. If, however, any good reason can be produced against such a practice, which would not be equally applicable to general surgery, one would like to hear it, excepting, of course, in such cases of cardiac, pulmonary or renal diseases as make it inexpedient or unsafe. We believe not only in giving it when asked for, but in urging it upon the suffering patient if timid or reluctant.

Preference is given to chloroform, and whether for simply obtunding the pains or for total anesthesia in obstetric operations, we urge that it is safe, easy to give, pleasant to take, rapidly recovered from, and not productive of initial excitement or subsequent vomiting. I believe that as an anesthetic in childbirth, it is practically as safe as ether. Whether this is due to physiologic hypertrophy of the heart developed during pregnancy cannot be told; but, except in children under eight, nowhere else is seen such immunity from its bad effects or dangers. Special skill is not required to administer it with such oversight as the operator can give during the early stage of anesthesia.

For administration use a single thickness of flannel stretched over a wire ring, four inches in diameter will do, care being taken not to touch the face with this inhaler. An ounce thus inhaled will suffice for an average case, as total surgical anesthesia is not usually necessary except for turning or high forceps. That it causes or predisposes to hemorrhage has not been evident in my experience, although I have used it during the last ten years in more than a thousand cases. Many times when the patient was getting exhausted from the pains, effort and fear, the rapid pulse has been found to go down several beats a minute, but to increase correspondingly in strength after the administration of chloroform.

As a routine practice the heart is always examined before giving the chloroform. Under these restrictions it is an ideal

anesthetic during the latter part of the first stage and during all of the second stage of labor. During delivery of the afterbirth or for suturing a perineal tear, it will seldom be necessary. Both ether and chloroform are carried in my bag, but ether is not used once to chloroform hundreds of times. To the sceptical, therefore, let me urge a few impartial trials. Justly proud of her great discovery of that great general anesthetic, ether, Boston has not been fair to chloroform.

We were not told to do digital dilatation in tedious but otherwise normal labors where the membranes had ruptured prematurely. With the fingers sterilized this is safe and more sure than are drugs. The use of morphin subcutaneously will make it more bearable, though, if the pains are severe, chloroform will be best given just short of producing unconsciousness. The manipulation also distends the entire genital passage.

Another important thing not taught was, that when such measures have been necessary, or forceps have been resorted to, the routine use of the intra-uterine douche ought never to be omitted, using biclorid 1 to 1000, and for this purpose the fountain syringe (which must be in the indispensable bag) and the ordinary glass irrigator. These latter have the advantage of metal in that they are transparent. The small size will be found to be very convenient in irrigating after incomplete abortions. No doubt sterilizing will make a blood-clot lodged in a metal irrigator innocuous, but it is not pleasant to contemplate the possibility of it.

The necessity of emptying the vagina and uterus of clots before making the final toilet of the patient was not sufficiently emphasized. This important measure ought to precede the douching.

Again, the value of the prompt suturing of perineal and other vulvar tears at the completion of labor was not enjoined. It would seem, at this date, unnecessary to urge the necessity of this operation did we not know that some practitioners still treat such by denying their existence. In my experience they occur as often in natural as in artificial deliveries, though, of course,

they may be more extensive in the latter, especially after instrumental delivery of non-rotating occipito-posterior head. For some years I have carried the head mirror of the laryngoscope to facilitate the application of the high vaginal sutures in extensive tears. An assistant to hold the lamp is all the help that is needed. Sterilized silk sutures seem best for this purpose. For twenty-four hours after this operation catheterization is advisable, sterilizing the catheter and cleansing the vestibule first.

It is not the fault of our teachers that bi-chlorid of mercury was not put in our hands instead of the bulky, numbing and uncertain carbolic acid. It is indeed a boon, yet we meet some who have not yet appreciated their relative values. The tablets furnished for this night and morning perineal toilet ought to be strongly colored and strict rules given for their exclusively external use.

I am sure that the majority of the profession will agree with me that we are using the forceps much oftener than was thought best twenty years ago. Personally I use them much earlier in all cases seeming to need them than formerly, and with far better results both to mother and child.

It took some time to learn that a severe and protracted labor paved the way for sepsis and hemorrhage, or both, and that almost every instrumental case did well if done early. This fact has permeated the public mind, too, and now the proposition to use forceps arouses no such dismay and objection as it once did.

I believe axis traction is secured with ordinary forceps by using one hand on the joint as a fulcrum, and while less convenient the result is thus obtained. The short forceps have been found of very great convenience; and though both short and long are always carried, the former are much oftener used.

Dismayed by a few unfortunate results in uremic cases, it now seemed best to drop the expectant plan and terminate pregnancy if severe symptoms develop before the seventh month. To delay may cost the patient her reason or eyesight, if not life itself, without giving much chance for a live baby either. After seven months,

if within easy reach, and the symptoms are not too urgent, we may temporize. The same line of practice seems best in the case of hydramnios. Very bad results to the mother have been seen from non-interference, with little accruing benefit to the baby.

Little was formerly taught about the mental phases of eclampsia other than the seizure alone. These may be preceded by a period of variable length, of automatic conduct, the patient keeping up and about but in a dazed and uncertain manner. This period will be a blank to her afterward so far as any recollection of it is concerned. If one does not know how to interpret these symptoms, he is liable to be taken unawares by a terrible attack of convulsions or coma which will open his eyes to the real state of affairs with her.

Some women in labor who are not suffering from renal troubles at all, will have what are practically attacks of transient mania during the first and second stages of labor. Morphin hypodermically and chloroform anesthesia will generally give relief, as the cause is pain and dismay.

In the treatment of incomplete abortion it is evident that we have not found it best to keep to the teachings of two decades ago. In some way the impression prevailed that prior to the tenth week there was no placenta, and so when confronted by a case at eight or nine weeks, giving the history of a ruptured sac with the escape of an embryo, we were inclined to lull ourselves into the fond belief that the worst was over. Soon hemorrhage, pain, and possibly septic absorption with escape of membrane and placental *débris*, made it clear that a slight degree of dilatation might give egress to a small embryo and still be too small to allow the escape of the actually larger mass of secundines even if the latter were detached from the uterine wall. That the placenta may not exist as an actively vascular go-between prior to the third month I cannot discuss, but as a matter of fact I do find a mass of material very like immature placental tissue after seven or eight weeks. It is the retention of this mass with the associated hemorrhage and probability of septic infection and absorption which renders this

condition one of insidious and concealed danger. These are often the cases where for moral reasons the fact of an abortion is suppressed until it often becomes its own Nemesis.

Sometimes a frank statement makes the diagnosis easy, but oftener we have to draw our own conclusions from reluctant half-true answers. If we fail to make an examination, valuable time will be lost and the doctor will lose any reputation for acumen which he may have as well. On examination the cervix will usually be found but slightly dilated, but more dilatable than usual. Firm supra-pubic pressure on the fundus and steady gradual insertion of one finger will find a capacious cavity and touch the mass of membranes, placental tissue or whatever is retained.

The discharge will sometimes have the order of moist decomposition, but too great reliance cannot be placed on this evidence, as some very septic cases will not give much odor and *vice versa*. The temperature will be up from 102° to 106°, pulse fast and weak from preceding hemorrhage, and an account of chills, sweating, etc., will be obtained.

Occasionally one of these cases will be found presenting an enlarged cervix and an everted os covered with a cauliflower-like granulation. This condition, when associated with hemorrhage and fetor may throw one off his guard. Once, after having practiced long enough to know better, I sent such a case to Carney Hospital as a case of cancer of the cervix. Luckily for both patient and myself, she fell into the hands of Dr. Swift, who relieved her of a retained and fetid placenta.

The history of an abortion ought to clear up the diagnosis. Whatever question may exist about the treatment of a recent non-criminal abortion, in the case of those with high temperature, chills, etc., it must be admitted that the only safe course is to empty the womb, and stop further septic irritation and absorption by dilating the cervix, curetting the lining and douching with bi-chlorid, 1 to 1,000. The dilatation generally secures subsequent drainage so that I have not found the insertion of a gauze drain necessary. No class of cases has given

me more satisfaction in the face of unpromising conditions than these.

In the treatment of puerperal fever, little was formerly advised by way of direct treatment to the utero-vaginal cavities. Curetting or intra-uterine injections were regarded as unsafe or too troublesome to give; but medicine and outside applications were unstinted. It was taught twenty years ago that two ounces of alcohol was as much as the system could assimilate to advantage in twenty-four hours. Of late, however, I have seen a septic case (puerperal fever) take ten times as much as that, with good results.

We were warned in school that if puerperal fever occurred in our practice we must give up all new cases for a period. Acting upon this theory I once lost twenty days' work. Lately, however, while caring for a very severe case of puerperal fever in which I had to make applications, give douches and perform other services involving handling the patient, seven other cases of obstetrics were attended, three of which were instrumental, and, though forced to do considerable of the nurse's work in these, too, no case showed infection. Sterilizing all the instruments by boiling, disinfecting the hands and bared arms, are precautions which leave little to be feared from contagion.

For the vomiting of pregnancy, our resources were formerly limited to cerium oxalate, etc. Later experience has taught me to place more reliance upon painting the cervix with a ten per-cent solution of argenti nitras, or slight dilatation of the os externa in cases of such severity as call for any treatment.

The benefits to be derived from position and support by well-applied compresses and bandages in suppuration of the breasts were not taught. Those were the days of poultices.

What instruction we had in extra-uterine pregnancy was not encouraging either as to diagnosis or treatment. Within the last decade so much advance has been made that we now know it to be far from uncommon, and, while startling in the event of rupture, it is easily recognized and very hopeful of recovery if treated promptly by laparotomy.

I regret to say that I have not as yet

mastered examination of fetal position by external palpation, nor incised laterally for rigid outlet, nor attempted the recently suggested primary operation for cervical tear—that is, suturing before leaving the chamber.

No doubt the near future will bring many innovations and improvements in our practice. Some have characterized as officious interference these measures that have proved useful to us. Parturition, they say, is a natural process which, they argue, can be left to nature. They forget that women at present are not in a state of nature. Engleman says that Indian women have Indian babies very easily, but have hard labors when they bear half-breeds, on account of the relatively larger heads of the half-white offspring.

Possibly the "new woman," with the advantage of better living, dress, athletic training and general education may need physicians less; but for the present we have to take cases as we find them, and, though it is no new or easy field, opportunity is given to save lives and reduce pain.

It requires some temerity to voice platitudes, much more to claim merit for procedures which do not have the sanction of the experts. Between the experts, who can waive aside as "trite" the problems that daily confront us, and the medical moss-backs who will not learn, there is still the bulk of the profession who need the opportunity to meet and exchange the small coin of personal experience as well as to draw on those whose greater opportunities and broader views enable them to give us the latest and best teaching. To this middle class, then, I appeal, being wholly willing, however, to abandon my way of doing when I can learn of a better.

WASPS AND SUICIDE—A short time ago, M. Henry, a Frenchman, being curious to see the effect of benzine on a wasp, put some of it under a glass in which a wasp was imprisoned. The wasp immediately showed signs of great annoyance and anger, darting at a piece of paper which had introduced the benzine into his cell. By-and-by he seems to have given up the unequal contest in despair, for he lay down on his back, and, bending up his

abdomen, planted his sting thrice into his body, and then died. M. Henry allowed his scientific interest to overcome his humanity so far as to repeat the experiment with three wasps, only to find that the other two did likewise. He is, therefore, of opinion that wasps, under desperate circumstances, commit suicide.—*Eclectic Magazine*.

His Pneumogastric Nerve.

Upon an average, twice a week,
When anguish clouds my brow,
My good physician friend I seek,
To know what ails me now;
He taps me on the back and chest,
And scans my tongue for bile,
And lays his ear against my breast
And listens there awhile;
Then, he is ready to admit
That all he can observe
Is something wrong inside—
To-wit: "My pneumogastric nerve!"

Now, when these Latin names within
Dyspeptic hulks like mine
Go wrong, a fellow should begin
To draw what's called the line.
It seems, however, that this same
Which in my hu'k, abounds,
Is not, despite its awful name,
So fatal as it sounds;
Yet of all torments known to me,
I'll say w'thout reserve,
There is no torment like to thee,
Thou pneumogastric nerve!

This subtle, envious nerve appears
To be a patient foe—
It waited nearly forty years
Its chance to lay me low;
Then like some withering blast of hell
It struck this guileless bard,
And in that evil hour I fell
Prodigious, far and hard.
Alas! What thing I dearly love—
Pies, puddings and preserves—
Are sure to rouse the vengeance of
All pneumogastric nerves!

Oh, that I could remodel man!
I'd end these cruel pains
By hitting on a different plan
From that which now obtains;
The stomach greatly amplified,
Anon should occupy
The all of that domain inside
Where heart and lungs now lie;
But, first of all, I should depose
That diabolical curve
And author of my thousand woes,
The pneumogastric nerve!
—Eugene Field, in *Cincinnati Med. Jour.*

SOCIETY REPORTS.**COLLEGE OF PHYSICIANS OF PHILADELPHIA.****SECTION ON OPHTHALMOLOGY.**

Meeting of the Ophthalmic Section of the College of Physicians of Philadelphia, March 16, 1897. The President, Dr. William F. Norris, in the chair.

DR. WILLIAM T. SHOEMAKER reported for Dr. Charles A. Oliver, a

Case of Traumatic Sub-Conjunctival Dislocation of the Lens.

A woman thirty-four years old fell and struck her right eye against the thumb latch of a door. Two days later the lens mass was seen resting upon the sclera in the upper inner ciliary region. The cornea was hazy, anterior chamber partly filled with blood, the iris retracted and tremulous and presented a large coloboma. No fundus reflex could be obtained. The lens was removed by conjunctival incision. No sutures were used and no reaction followed. At present the scleral scar is firm and discolored and the coloboma unchanged. The remnants of the torn capsule are faintly visible in the pupil. Vision with a correcting glass is $\frac{1}{10}$.

DISCUSSION.

DR. W. F. NORRIS stated that it was his experience that staphyloma frequently followed injuries of this character when the edges of the ruptured sclera were not united by sutures. The fact that the pupil is crossed by a few opaque fibers of capsule shows that the capsule was ruptured at the time of the accident.

DR. G. C. HARLAN referred to a case of dislocation of the lens under the conjunctiva, in which he had seen the patient occasionally for several years. There was useful vision and the eye was not interfered with as it remained quiet. In another case he had removed the lens by incision. It was found that the rupture of the sclera had been closed chiefly by the adherent lens capsule, and a cystoid cicatrix resulted, followed later by a considerable staphyloma. In all the cases he had seen the lens had been forced out through the upper corneoscleral junction. This is usual in this accident, which is generally the result of a blow from a blunt instrument, such as the fist or a billet of wood, striking the ball below and forcing it against the roof of the orbit. The sclera is ruptured by contrecoup and the lens is extruded.

DR. M. W. ZIMMERMAN reported a

Case of Bilateral Pigmented Tumors, Probably Cysts of the Ciliary Bodies.

Mrs. J., aged fifty-nine, with good family history had been under observation since April, 1893, when she was seen by Drs. Harlan and Jackson in consultation. In the lower and outer quadrants of both eyes the iris was crowded forward by dark brown tumors presenting into the pupil between the lens and iris. The tumors, examined under mydriasis, were smooth and not nodulated and apparently not attached to the iris. Since the irides were not involved and the tumors could not be removed by iridectomy, no operation was advised and no treatment other than weak eserin was used. During the past four years the tumors had changed somewhat in outline, and that in the right eye very slightly increased in size. In other respects the eyes were normal. There was no iridodialysis or other injury to the iris tissue. Vision equaled one-third of the normal.

DISCUSSION.

DR. HARLAN had agreed that the iris did not participate in the disease. The case was decidedly obscure, but he believed that it would prove to be ciliary sarcoma. The absence of an important symptom of neoplasms in the region, namely inflammatory reaction, was noted. Usually the growth is adherent to the adjacent iris, and as it progresses into the pupil it carries the margin of the iris with it, producing iridodialysis. He thought, however, that this might occur later. But as it had not done so in four years, and as there had been but little change in the condition of the eyes, he thought now that the presence of a malignant tumor was hardly possible.

DR. G. E. DE SCHWEINITZ read a communication on

Angioid Streaks in the Retina.

After briefly reviewing the literature and referring to his previous case, reported to the Section on Ophthalmology and to the American Ophthalmological Society, Dr. De Schweinitz presented a second bilateral example of extensive branching, pigmented striae in the retina, the anastomosing bands being easily traceable to their points of origin in hemorrhages. The patient, a brother of his previous case, was a working man, fifty years of age, who had been

a hard drinker, but who had suffered from no notable illness. Examination of the heart, kidneys, and blood yielded negative results. The pathology is obscure, and we are at present unable to say more than that these cases represent an unusual metamorphosis of retinal hemorrhage.

DR. EDWARD JACKSON suggested a

Modification of the Sight-hole of the Ophthalmoscopic Mirror,

to avoid all annoying reflexes from it. This consisted in making the sight hole merely through the silvering, leaving the glass intact, and then cementing a thin piece of glass back of the sight-hole, extending beyond it on the silvering to protect it from dust. The dust falling upon either surface being easily removed, complete and permanent freedom from the luminous cloud caused by reflexes from the sight-hole can be obtained. The plan had been first applied to the mirror for skiascopy, and later adapted to that of the ophthalmoscope.

DR. WILLIAM M. SWEET presented, by invitation, a novel apparatus for

Determining the Location of Foreign Bodies in the Eye by the Roentgen Rays.

By means of three horizontal rods of aluminum, each with a rounded extremity to be adjusted to the inner and outer canthus, and to the centre of the upper lid, held in position on the patient's face by a band similar to that of the head-mirror, shadows are cast on the sensitive film. He prefers the double film to the glass photographic plate on account of its flexibility and lightness, and because mistakes in diagnosis incident to imperfections in one film or plate are avoided. The Crooke's tube, held thirteen inches upward and backward opposite the parietal bone, emits rays that pass through the external orbital wall, the tissues surrounding the ball, and the ball itself, and are received on the film, which has been thrust as far as possible into the inner canthus, and maintained in position by a holder.

Two exposures are made; one with the tube on a line with the eye, and the other at an angle of twenty five degrees with the horizontal plane.

The approximate position of the foreign body is determined by attaching the apparatus to an upright support, and so placing a lighted candle that the shadow cast by the indicators will fall similarly to those thrown by the Crooke's tube. A small object is then held before the candle in such a position that its shadow is identical to that of the foreign body. A record having been made of this line of shadow, the candle is moved until the shadows of the indicators correspond to those on the

second negative. The object is again employed, and a second impression recorded. Where the two lines of shadow of the test object cross should be the situation of the foreign body in the eye. Knowing the distance of the centre of the cornea from a fixed point of the apparatus, the distance that the foreign body in the eye lies behind this point, and therefrom its approximate position may be measured.

DR. G. E. DE SCHWEINITZ presented a

Case of Suspected Sarcoma of the Ciliary Body

in a girl aged six and one-half years, with the symptoms of cyclitis, associated with marked iris bombé, the upper and outer portion of the bulging iris being of a grayish-black color, while the lower portion was of a greenish-blue. These symptoms had existed, according to the history, for about three months, with occasional exacerbations of the cyclitis and periods of increased tension. The pupil was occluded, and there was a small central corneal scar, but history of injury could not be obtained. Skia-graphic examination was negative. The bulging of the iris had notably increased during the last few weeks, and symptoms of sympathetic irritation were evident in the sound eye.

DR. C. A. OLIVER showed a

Case of Supposed Foreign Body in the Eyeball.

The left eye had been injured by a piece of flying metal from a steel drill some two weeks previously. The line of injury extended through the cornea at its lower inner quadrant, the inferior nasal portion of the iris, and the lens, with a localized detachment of the retina and choroid at corresponding points. The pupil was heart-shaped. The media, with the exception of the isolated lens opacity, were clear. No foreign substance could be seen.

Through the courtesy of Dr. C. L. Leonard, of the Pepper Laboratory of Clinical Medicine, the case is now being studied with the X-ray apparatus. A number of exposures are being made from different positions so as to obtain, if the body be present, a series of triangulations from which the actual situation of the foreign material can be determined.

DR. C. A. OLIVER showed a case, with water-color sketches by Miss Washington, illustrating both the early and the late appearances of

Thrombosis of the Inferior Temporal Vein

of the left eye, the conditions being found, at an interval of two years, in a young man without any history of traumatism or relevant dyscrasia.

PERISCOPE.

Certain experiments in regard to the elimination of iron in the economy, have recently been made by Cloetta (*Archiv. Pathologie und Pharmakologie*). For this purpose he used ferratin, which exercises no caustic action on the tissues. His experiments demonstrated that, in dogs which were subjected to a milk diet, the iron injected into the veins in the form of ferratin, was eliminated by the large intestine. Quincke had also ascertained this by micro-chemical examination. The author also investigated the means of assimilation of this element when administered by the digestive tract, and he found that twenty per cent. of a dose of ferratin introduced into the stomach of a dog subjected to a milk diet was absorbed. According to M. Cloetta, the organic combination of iron with albuminoid matter is necessary in order to insure its absorption. For instance two dogs were experimented upon as follows: Their food consisted of a soup made of starch, sugar, glucose, and distilled water. To the nourishment of the first dog a solution of iron chlorid representing sixty milligrams of iron was added; to that of the second dog, a solution of ferratin representing forty milligrams of iron. The villosities of the dog to which ferratin had been given presented the characteristic action of the iron absorbed. The iron contained in the intestine of the other dog was not absorbed and formed masses at the base of the villosities. The organic iron combined with albuminoids is evidently absorbed in the intestine, penetrates the chyle, and enters the circulation by the mesenteric veins. Experiments made by Cloetta with newborn dogs demonstrated that the presence of iron salts in the food was not immaterial to the formation of hemoglobin, that there was no absorption of iron salts and that the liver seemed to regulate absorption in the same way as it did glycogenesis.—*New York Medical Journal*.

Chian turpentine has been found very useful in every form of internal hemorrhage, even where ergotin has failed. Mr. James, of Bombay, reports, in the *Indian Medical Record*, its successful use in hemoptysis of phthisis, post-partum hemorrhage, cancer cervix uteri, sloughing cancer of the breast, epistaxis in a "bleeder," etc. He also claims anodyne results in painful cancers.

A case of temporary paralysis appearing suddenly in the course of an attack of gastric disturbance has been observed by Boux (*Jour. de Med.*). The patient who had been suffering from dyspeptic symptoms of a mild degree for about a week, suddenly suffered from general weakness, fever, and lumbar pain, which

in the course of some hours resulted in complete paralysis of the lower limb, diminution of the knee-jerk, and of sensation of pain, the sphincters being unaffected. This condition lasted a week, disappearing as rapidly as it came on, and without leaving any trace. The author, without committing himself to any diagnosis, draws attention to the analogy presented by this case with acute spinal paralysis. The case, however, seems to differ in some respects from ordinary cases of this disease, more particularly in the fact of the pain sensation being altered.—*British Medical Journal*.

Considerable light has been thrown on the structure of Nasmyth's membrane by the recent researches of Mr. Paul of Liverpool. Hitherto this tissue has generally been regarded as a thin layer of cementum, but from Mr. Paul's specimens there seems to be little doubt that it is at any rate epithelial in character, and therefore in all probability a remnant of the enamel organ. He has shown that the membrane is composed of two layers, the outermost being composed of large flattened epithelial cells, beneath which is a thin, translucent pellicle usually marked with hexagonal impressions derived from the ends of the enamel prisms. Mr. Tomes, who has been the principal advocate of the cementum theory, has in a recent issue of the *Dental Record* acquiesced in the views held by Mr. Paul.—*The Lancet*.

A bill providing for the payment of debts through which the doctor will benefit is before the New York legislature. Its provisions are as follows: Executors and administrators must proceed to pay debts in the following order: 1. Debts entitled to a preference under the laws of the United States. Taxes assessed on the property of the deceased previous to his death. 2. Debts of the deceased, because of services rendered and materials furnished by physicians, pharmacists, nurses, and undertakers. 4. Judgments docketed, and decrees entered against the deceased according to the priority thereof respectively. 5. All recognizances, bonds, sealed instruments, notes, bills, and unliquidated demands and accounts. Preference shall not be given in the payment of a debt over the other debts of the same class except those specified in the fourth class. All debts specified in the third class shall become due upon the death of the deceased, and shall be paid within ninety days thereafter.

A case of absence of the umbilicus is reported in the *Medical Gleaner*. The boy was eight years old, and the integument was perfectly plain and smooth over the entire abdomen.

It has been predicted by eminent medical men that the mescal button (anhalonium Lewinii), when it becomes better known and more easily procurable, will become the factor in a drug habit more alarming than that of cocaine or morphin.

The regular meeting of the Section on Pathology, Buffalo Academy of Medicine, was held in Alumni Hall, University of Buffalo, April 20, and, Prof. Charles Wright Dodge, of Rochester University, gave a lecture entitled, "Recent Progress in Cellular Biology, illustrated."

Incontinence of urine in children and adults is treated by the Fiorani method, which consists in attaching to the wrist a weight of from fifty to one hundred grams, hanging over the foot of the bed. Considering the condition one of physic origin, or, as he expresses it, a somnambulism of the bladder, the mechanical treatment is usually efficacious.—*Medical Record.*

A case of primary Carcinoma of the ureter is related by A. F. Voleker (*Birm. Med. Review*). The patient was admitted with hematuria, lumbar pain, enlarged, nodular, and tender liver, and some resistance to palpation in the left iliac fossa. He rapidly became emaciated and died in a few weeks. The liver was infiltrated with a pale, soft pus growth. The left kidney was small and hydro-nephrotic; in the lower two inches of the ureter was a delicate villous growth projecting into its lumen, and outside a mass as large as a cherry adhering to the pelvic brim. Microscopically the growth was a villous carcinoma, and the secondary deposits in the liver had a very similar structure.

Eight things a physician should remember are thus given in the *Public Health Journal*:

1. That disease is simply an unbalanced state of health.
2. The most maladies are complex in character, and the complication often exceeds in importance the primary disorder.
3. That every morbid phenomenon, however obscure and remote, has its reason and cause.
4. That prominent symptoms are frequently situated at some distance from the seat of disease.
5. That most derangements are atypical, varying with the personality and environments of the patient.
6. That every active remedy excites reaction as well as action.
7. That a stimulant is merely a spur, and that a narcotic is a gag, stifling the cry of nature for relief.
8. That proper diet, clothing, climate, and occupations, with rest, are the chief means for the preservation of health.

The cases in which gout appears in connection with joints may, from a clinical point of view, be conveniently divided into three classes: (1) the acute attack of regular gout; (2) chronic gout, possibly a sequel of an acute attack with much deposit of urates in a solid or semi-liquid state; (3) pains referred to the joints of a more or less fugitive character, or tenderness felt chiefly on use, which later may, if excessive, be followed by increase of pain and even some redness and swelling or an attack of the first variety. In the second case, with more deformity, there is much less pain and tenderness, though along with these, redness and superficial swelling may from time to time be superadded with an increase of deposit within the joint. In addition to these conclusions, Sir Willoughby Wade (*British Medical Journal*) says that in an attack of gout which has effected the metatarso-phalangeal articulation of the great toe, lines of tenderness can be detected running from the joint across the dorsal and plantar aspects of the foot in the line of the nerve supplying the joint. This nerve affection sometimes has the character of a neuritis and at other times that of a neuralgia and may, therefore, be described as a neurosis. The lesion may arise from injury or from the presence of some toxic agent in the blood. A neurosis is the primary and essential element. If a sensory nerve is attacked, we get pain and tenderness; if a vasomotor nerve we get redness and swelling; if the nutritive nerve of a joint we get changes in the joint, one result of which may be a deposit of urates. It may be asked how one toxin (uric acid) affects now an external, now an internal sensory nerve; now a motor, now a vasomotor; now a trophic nerve and again an excretory one. This condition causes us to hesitate before we declare positively that gout is dependent upon uric acid as a cause.

The importance of hernia in causing digestive disturbances, especially hernia through the linea alba, is emphasized by Kuttner (*Medizin u. Chirurgie*). These disturbances may range from simple flatulence and anorexia to the most severe forms of colic, and he especially calls attention to the exclusion of the rarer forms of hernia in diagnosing such cases. Among these forms he lays stress upon herniae of the linea alba, which include the not rare extrusions through the fascia of pedunculated fatty tumors from the subperitoneal tissues. These occur most frequently in laboring men, in the epigastric region, and are very liable to be overlooked and give rise to diagnosis of gastric ulcer, etc. The most important cause is trauma, and the typical symptoms are tenderness over the hernia, pain in severe attacks, usually caused by strong exertion, large or indigestible meals, and often vomiting. The general symptoms may be slight or go on to syncopal stupor. Vomiting may become so incessant as to endanger life. Not infrequently the symptoms are only those of mild gastritis or neurasthenia. Diagnosis is made by discovery of the tumor.

which often gives the feeling of spouting when compressed, and by the absence of any signs of other causes, such as gall stones, gastric ulcer, and nephritic colic. When a tumor is absent, the especial difficulty in diagnosis is gastric ulcer, which may be excluded by the distinctly paroxysmal attacks of pain occurring at long intervals with no intervening dyspeptic symptoms, the lack of hematemesis and of evidence of disturbance of the gastric secretions. The only treatment is radical operation when one will find the sac sometimes containing a knuckle of bowel—often a portion of omentum—and sometimes empty. Kutner recites cases of his own which, though exhibiting severe symptoms, were entirely relieved by operation.—*Int. Jour. of Surg.*

The treatment of chronic acne where there is no constitutional cause for the disease, by incision of each vesicle or pustule with the fine point of a knife and placing a drop of hydrogen dioxid well into the cavity, is recommended by the *Texas Medical News*. A wooden toothpick trimmed down to a flat point dipped in the dioxid answers every purpose for getting the remedy into the incision. One such operation usually suffices to effect a cure of the particular vesicle or pustule. Pure carbolic acid was employed in pretty much the same manner previous to trying the dioxid, but while the acid permanently destroyed the eruption, there was greater pain from its use and greater liability to leave behind cicatrices. So far the dioxid has been as effectual as the acid, and in no instance has there resulted disfigurement. The comedones and finer eruptions are scraped off with a knife, and some mild alkaline soap and warm water are used on the face once a day. In some instances, where the skin is disposed to be harsh, cold cream is used with massage once every day or two.

The greater frequency of sesamoid bones in the female than in the male hand has been demonstrated by F. J. Reid (*Medical Age*), through a series of skiographs. He says that in females a sesamoid is most often found in the metacarpo-phalangeal joint of the little finger, less frequently in the index; in one case there were two in the inter-phalangeal joint of the thumb, and, in this hand—including the two always found in the metacarpo-phalangeal joint of the thumb—there were no less than six sesamoids. In male hands the bones seem to be more evenly divided between the index and little fingers. Sesamoids as a rule are proportionally larger in the female than in the male.

Grave inconveniences may arise from the employment of sodium salicylate in acute articular rheumatism with visceral localizations according to M. Jaccond (*Lyon Medical*). Not only does it not cure these manifestations, but it does not prevent them, and it may even favor the production of certain of them. This

drug seems to favor the cerebral symptoms of rheumatism, and its employment should be suspended as soon as delirium sets in, before the diagnosis of cerebral rheumatism is established. This suppression is necessary also if the delirium is of an alcoholic or hysterical nature, or if it arises from any form of intoxication. It is the same also in cardio-pulmonary localizations, which are much more important on account of their frequent occurrence. During the past ten years M. Jaccond has observed that the salicylate acts on the pains and on the fever, but not at all on these localizations, and as it has a depressing action on the heart from the time these symptoms appear, its use must be discontinued. By persisting in its employment involvement of the myocardium in the disease is certainly hastened. Numerous statistics show, moreover, that these localizations are not cured or even prevented.—*N. Y. Med. Rec.*

Hutchinson states that in Dupuytren's contraction of the palmar fascia, it is an error to suppose that the palmar fascia alone is involved (*Archives of Surgery*). The cellular tissue thickens and forms adventitious bands. In some instances the skin is thickened and contracted. The predisposing causes are hereditary gout, inheritance, and gouty tendencies in the patient. The exciting causes are pressure, injuries, and arthritis. In many cases no exciting cause has been present. Indurations may occur in other parts of the body, of the same nature, and in association with the disease. The fibrous structure of the penis may be involved, causing curving and difficulty in copulation. He thinks one of the causes of glaucoma may be analogous contraction of the sclerotic. Acute glaucoma and Dupuytren's contraction occur in much the same class of persons, at the same period of life, and in the same association with inherited gout. It is to be noted that by inherited gout he means something quite different from gout as ordinarily understood. It has nothing to do with the deposit of urate of soda in the tissues, nor probably with its presence in the blood. It is rather a peculiarity in the proclivities of fibrous structures, derived by inheritance from gouty ancestors. Dupuytren's contraction is found in gouty families rather than in gouty individuals. Many who develop it as a matter of inheritance, are quite free from evidence of active gout. The subject who manifests it in middle life, possibly from exciting causes, has inherited fibrous structures which do not wear well; they harden and contract under continued irritation. The rare form which appears in children, and is sometimes congenital, is yet more definitely hereditary. Some progenitor—pace Weissmann probably actually had at the time he became a father some existing changes of this kind.

A special meeting of the Buffalo Academy of Medicine was held Monday, April 19, to protest against the proposed changes of Civil Service Laws affecting Boards of health.

The treatment of eclampsia was discussed in detail at the recent Congress of Gynecology and obstetrics at Geneva. Charpentier, claiming to represent the French school, said that when the patient was seized with eclampsia and labor appeared spontaneously, all were agreed that the right treatment was to terminate labor as quickly as possible. But when eclampsia set in before labor, a distinction must be made between the cases at or nearly at term and those early in pregnancy. The German school considers the induction of premature labor or even abortion or forced delivery the only treatment. Duhrssen incised the cervix deeply, and if necessary the vulva and perineum; Bossi uses instrumental, others manual dilatation; others again would resort to Cæsarean section. Charpentier is convinced that induction of labor is useless, and forced delivery dangerous. He concludes that:

1. The urine of every pregnant woman should be examined.
2. If the least trace of albumin is found she must be put on a strict milk diet, which prevents the production of toxins; this must be continued till after labor and till no albumin is present.
3. When edema without albuminuria is found the milk diet is indicated.
4. When eclampsia occurs with cyanosis in a strong woman, bleeding up to half a liter must be performed.
5. Chloral should be given.
6. When convulsions have set in, milk should be given by the mouth, or, if necessary, by the esophageal tube; this alone sometimes causes cessation of the convulsions.

Besides this the fits should be treated with chloroform inhalations and diuresis induced by subcutaneous injections of normal saline solution. One must then wait till normal labor sets in. If there is inertia uteri, labor must be terminated by forceps or version if the child is alive, by basiotripsy if dead. Induced labor is only exceptionally necessary, and forced delivery never.

Halbertsma, Mangiagalli, Bossi, Pasqualini and others spoke on the other or "German" side, and advocated early emptying of the uterus, very favorable statistics being brought forward in support of this.

Trial has been made of eucain in the out-patient surgical department of Jefferson Hospital, and the results have been most satisfactory. In the removal of ingrown toenails we have a procedure which brings a local anesthetic to the test, and in these usually painful operations eucain has proved more satisfactory than cocaine, the anesthesia from eucain being more profound and prolonged and widespread than is that from cocaine.—The American Year-Book of Medicine and Surgery, Gould (1897) Department of General Surgery, by W. W. Keen, M.D., and John Chalmers Da Costa, M.D.

It is becoming conceded that the spleen plays an important role in all infectious diseases, but in them all malaria offers the most characteristic lesions of the organ. In acute malarial poisoning pathologic anatomy shows the spleen enlarged and softened, transformed into a sort of brownish, semi-fluid mass where the microscope discovers a large number of hematozoons and pigmented elements. In chronic cases where the patient dies from some intercurrent disease malarial germs will always be found in the spleen. In the same cases during intervals of acute or pernicious attacks puncture of the spleen invariably shows the parasite even when the result of the examination of the blood is negative. It is also known that every traumatism of the region of the spleen in chronic cases is followed by a revival of malarial symptoms and where the spleen has been removed on account of its excessive hypertrophy, future attacks of malaria, when there are any, are noticeably mild. From these facts it may be concluded that the spleen is not an organ of protection for the organism against the malarial infection, but that it is, on the contrary, a place of refuge for the disease. Furthermore, as the spleen presents the same appearances in other infections, as it does in malarial infection, it is probable than a similar condition of affairs obtains in all infections, and thus the role of the spleen in these diseases is very different from what has generally been believed. In conclusion, the more frequent performance of splenectomy in chronic malarial poisoning, should be urged especially where the organ is greatly enlarged.—LAVERAN before the Academy of Medicine.

Every medical man should be a member of a medical society. He will never know how great a man he is till some one praises him in a discussion, nor how small a man till some pompous fellow-member takes him to task; but all these frictions serve but to round and smooth a busy life, and no one can do without it who desires to be a physician in the highest acceptancy, and not a man who doctors.—*Atlantic Medical Weekly*.

Primary carcinoma of the pleura in a man aged 54 was reported to the Society for Innere Medizin by C. Benda (*Med. Press*). The patient stated he had had chest trouble for a year, and that the left chest had been punctured. A pleural exudation was again discovered. There was no pyrexia, no albumin in the urine, and the heart was sound and the patient well nourished. Two liters of clear serous fluid were removed on aspiration. Within the last six months ten aspirations had to be made on account of the rapid return of the exudation. Finally resection of rib was performed, when a carcinoma-like growth was discovered on the pleura. The fluid removed was still of the same character as previously, but pyemia soon set in, and four weeks after the operation the man died. The autopsy showed suppuration of the fluid in the chest (from which the *bacillus pyocyanus* was later on cultivated), metas-

tatic abscesses in the kidney and skin; on the costal, pulmonary and diaphragmatic pleura, and nowhere else, were bulky tumor nodules of a condyloma-like form, covered with pus. The pleura was healthy only in isolated spots. Microscopically, the tumor showed itself to be a carcinoma with latent development. The interior was pathologic. From Virchow's standpoint, there was nothing singular in the development of a carcinoma from the pleura, but other views on the subject had been disseminated by Thiersch and Waldeyer. According to them, carcinoma only developed from the superficial epithelium; where this was absent, as in serous surfaces, there could be no true carcinoma. Later on, E. Wagner opposed this view, and, from his investigation, he assumed an endothelial carcinoma. This dispute might now be ended, as it could only have arisen from an idea of an essential difference between the two surfaces. Recent inquiries had shown how the epithelium of the Fallopian tubes was continued on to the peritoneum. From this change of view, there had arisen a change as to the occurrence of carcinoma on serous surfaces. Up to the present no case had been published concerning these new views, so that the case shown might be considered as the first that afforded any proof. The specific distinctions between these tumors and other carcinomata lay in the number of nodules spread over the whole of the pleura and the absence of metastasis.

A case of unilateral strumectomy for Basedow's disease is reported by Wolff to the Berlin Medical Society (*Medical Press*). The case began in 1891 with chlorosis, afterward psychical excitement came on and then a morbus Basedowii developed. For a year internal remedies were given, the disease manifestly getting worse. In May, 1892, she was admitted into his klinik, and shortly after left-sided strumectomy was performed; the part removed weighed 86 grm., the weight of the remaining portion being estimated at 100 grm. The trachea was flattened as usual in such cases. Recovery was uninterrupted, and in twenty-five days the patient was discharged. Immediately after the operation the dyspnea ceased, but the other symptoms appeared to be uninfluenced. In the course of three months, however, the weight increased and the trouble diminished. Now after four years the patient was absolutely free from all subjective disturbances, the disposition had become equable, there was no palpitation. She had since married and borne two children, without any disturbance to her condition. Objectively a goitre the size of a plum still remained on the right side and a slight degree of exophthalmos. The Gräfe symptom was indistinctly present, Stellwag's and Möbius's were absent. Pulse and heart perfectly normal, hernia slight and the electrocutaneous resistance unchanged. The improvement of the symptoms in the case was longer than in others described. The case proved that operation should not always be re-

jected in Basedow's disease. If the operation did good there must be some connection between the goitre and the disease, although we could not say what was the nature of the connection.

A case of violent jactitations lasting twenty-two years and chiefly affecting the left arm and leg has been reported in *The Lancet* by Guthrie. It was treated by trephining and excising the arm center in the right motor cortex. The movements were ataxic, choreoid, and clonic in character. They were increased in violence and amplitude by attempted voluntary actions. Voluntary actions on one side appeared to set up and intensify involuntary actions on the other side. The movements ceased during deep sleep, but frequently woke him up when in a dreamy condition. They were practically absent so long as he lay in complete repose and was undisturbed. Those of the left arm were in part voluntarily controlled by inward rotation and inversion of the limb, the hand being pronated and confined to the hip by a strap passed round the waist. When released from this position the movements were extremely difficult to subdue. Those of the left leg were similarly controlled by inversion and inward rotation of the limb, giving rise to a peculiar gait. The other symptoms were external strabismus and proptosis of the left eyeball, elevation of the upper eyelid, with dilatation and fixation of the pupil. The right eye was unaffected. The tongue deviated strongly to the right on protrusion. The speech was drawling, hesitant, and of varied intonation. The symptoms seemed to indicate functional perversion of the right motor area of the cortex. The patient was therefore trephined and this area exposed. The cortex was healthy in appearance, but on electrical stimulation of the face and thumb centers fits of Jacksonian epilepsy were produced. The thumb center with the adjoining areas of cortex, measuring about one and a half inches in diameter, were excised. The result of the operation was complete paralysis of voluntary movement of the left hand and arm, lasting about a week. During this time he had seventeen epileptic fits, at first affecting the right side only, but latterly becoming universal. The left arm, however, during the intervals between the attacks remained flaccid and motionless. He also showed symptoms of partial bulbar paralysis for several days. After a week had elapsed voluntary and at first normal actions of the left arm were recovered, but they became increasingly jerky and ataxic, until three months later his condition was as it had been before the operation. It is concluded that:—1. The excision of single cortical centers is only likely to arrest movements permanently when they are extremely limited in range and extent, but in such cases the operation is unnecessary. 2. In severe cases such as the present extensive removal of cortical areas might possibly arrest the movements permanently, but the possible advantages of the operation are outbalanced by its dangers.